Washington State Medicaid
Inpatient Hospital Reimbursement System Redesign
State Surveys

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Note: NCI completed preliminary research to support the preparation of a state survey for New Jersey, one of the "core" states for this project. However, because NCI was being considered for a project similar to this one for New Jersey Medicaid, and because the project was part of a formal contract procurement process (which is still active as of the date of this report), we were advised by the State of New Jersey to not to make contact with the Medicaid program staff to complete the survey. Therefore, the state survey for New Jersey was not completed.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Illinois Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	• CMS/Medicare DRG: – Acute hospitals (per 89 IAC 149.50(a)(1)) ▪ DRG payments have been frozen since 6/30/95. • Fixed per diem (per 89 IAC 149.50(c-d)): – Rehabilitation hospitals and DPUs – Psychiatric hospitals and DPUs – Children's hospitals – Long-term stay hospitals – Sole Community Hospitals – University of Illinois at Chicago hospital – Cook County hospital
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Information not provided. ▪ AP-DRG or CMS/Medicare DRG _____ % ▪ Percent of billed charges _____ % ▪ Fixed payment per case _____ % ▪ Fixed per diem _____ % ▪ Other Method _____ %
1.3		How are the following services paid for?	<u>**Neonate Services**</u> • Non-Level III centers are reimbursed for neonatal services under the standard DRG payment methodology.

ID	TASK	QUESTIONS	RESPONSES
			• Level III perinatal centers are assigned new neonatal DRGs (985-989) that replace the standard neonatal DRGs (385-389)(per 89 IAC 149.25(d)(2)). – Perinatal center DRGs are based on adjusted CMS/Medicare relative weights for DRGs 385-391 (per 89 IAC 149.100(a)(2)(B)). The neonate relative weight calculation is as follows: [(Neonate DRG hospital-specific mean cost per discharge)/ (DRG 391 Normal Newborn hospital-specific mean cost per discharge)] x (DRG 391 Medicare relative weight) ▪ Neonate DRG hospital-specific mean cost per discharge: calculated by first summing the product of charges, as reported by a hospital on claims paid by the Department. Then capital, direct and indirect medical education costs are subtracted from the sum product. This difference is updated to the current rate year using the national hospital market basket price proxies (DRI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report. The inflated summed charges are then divided by the number of discharges for that DRG. **Transplant Services** • Reimbursement for organ transplants is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for a maximum number of days listed below for specific types of transplants (per 89 IAC 148.82(g): – 30 consecutive days of post-operative inpatient care for heart, heart/lung, lung (single or double), pancreas, or kidney/pancreas transplant. – 40 consecutive days of post-operative inpatient care for liver transplant. – 50 consecutive days of post-operative inpatient care for bone marrow

ID	TASK	QUESTIONS	RESPONSES
			transplant (this includes a maximum of seven days prior to the transplant for infusion of chemotherapy), or 50 consecutive days of care for an inpatient or outpatient stem cell transplant. – 70 consecutive days of post-operative inpatient care for intestinal (small bowel or liver/small bowel) transplants. – For inpatient intestinal (small bowel or liver/small bowel) transplantation for children, the number of consecutive days of inpatient care specified within the transplant certification process. **Rehab Services** • Per Diem (per 89 IAC 149.50(c-d)) **Psych Services** • Per Diem (per 89 IAC 149.50(c-d)) **HIV Services** • CMS/Medicare DRG: IAC does not explicitly exempt HIV services from the DRG system in section 149.
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	• Relative weights for DRGs with fewer than 100 records are calculated by determining the midpoint between the Illinois relative weight and the Medicare relative weight (per 89 IAC 149.100(2)(E)). • Relative weights for DRGs with fewer than 32 records are based on the Medicare relative weight (per 89 IAC 149.100(2)(E)).
1.5		What percentage of total payments do the following services represent?	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
			Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ % AP-DRG low volume _____ %
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	**DSH**: • Hospitals serving a disproportionate share of low income patients qualify for the following DSH payments (per 89 IAC 148.120): – Five Million Dollar Fund Adjustment: $5 per day add-on to the current hospital payment rate. – State-Operated Facility Adjustment: The state DSH Pool is multiplied by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs. – Assistance for Certain Public Hospitals: ▪ A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, section 701(d)(3)(B) for the DSH determination year; ▪ Divided first by Illinois' Federal Medical Assistance Percentage; and ▪ Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection (k)(4) of this Section; and ▪ Multiplied by each qualified hospital's Medicaid inpatient days as defined in subsection (k)(4) of this Section.

ID	TASK	QUESTIONS	RESPONSES
			<u>GME</u> • Direct medical education per diem payments are made to DRG-exempt hospitals. Please see the discussion of fixed payment per case below (ID 3.8) • No medical education payments are made to hospitals reimbursed under the DRG system (per discussion with Department).
1.7		Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	• DSH payments consist of a $5 million pool (per discussion with Department).
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	• Billed charges have increased. Outlier payments, which are based on billed charges, have increased (per discussion with Department).
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	• Hospital volume has increased as well as eligibility. Migration from Inpatient care to Outpatient care is occurring, but is slight (per discussion with Department).
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	• Projected 18% growth from FY 2004 to FY 2007 (per discussion with Department).
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	• CMI has been cyclical year to year, flat over time (per discussion with Department).
1.12	2	What portion of inpatient hospital payments have been made for outlier	• Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		cases?	
1.13	2	What have been the payment/utilization/methods for RCC claims?	• Not applicable.
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	• Illinois uses the CMS Medicare IPPS DRG grouper in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations (per 89 IAC 149.5(c)(1)).
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	• Conversion factors (called "DRG PPS base rate") are based on the Medicare IPPS (per 89 IAC 149.100(c)). Conversion factors equal the sum of the following components: – Federal/Regional Blended Rate Per Discharge: Medicare IPPS hospital operating acute base rate as computed by the PPS Pricer in effect 90 days prior to the date of admission. – Hospital-Specific Portion: any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers, Medicare dependent hospitals, and rural hospitals deemed urban.
2.3	3	Is there a geographic component to the conversion factor setting	• Acute base rates are subject to the Medicare IPPS regional adjustments such as Wage Index.

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
		methodology? Describe?	
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	• Conversion factors include an IME adjustment. Please see the discussion of conversion factors above (ID 2.2).
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	• Not applicable.
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	• The IAC does not distinguish between border and non-border out-of-state hospitals. Instead, it distinguishes between participating and non-participating hospitals. Please see the discussion of the out-of-state hospitals below (ID 6.1). • Participating out-of-state hospitals are paid under the DRG system. Nonparticipating out-of-state hospitals are reimbursed under the per diem methodology. Please see the discussion of the out-of-state reimbursement below (ID 6.2).
2.7	3	What method was used to establish relative weights?	• The Illinois Medicaid weighting factor for each DRG is based on the Medicare relative weight in effect 90 days prior to the date of admission for that group (per 89 IAC 149.5(c)(2)). • The Department then multiplies the Medicare relative weight by an adjustment factor (per 89 IAC 149.100(a)(2)(A)). – Adjustment Factor: Medicaid DRG geometric mean length of stay divided by the Medicare DRG geometric mean length of stay. ▪ The Medicaid geometric mean length of stay for each DRG is calculated using the same methodology used for the Medicare geometric mean length

ID	TASK	QUESTIONS	RESPONSES
			of stay from data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases. • The DRG relative weights are also multiplied by a base rate factor (per 89 IAC 152.150(b)). Relative weights have been frozen since 6/30/95, thus the base rate factor no longer makes DRG system budget neutral. – Base rate factor: the statewide weighted average DRG base payment rate in effect for the base period divided by the statewide weighted average DRG base payment rate for the rate period.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	• DRG claims - capital per diem add-ons: based on what was in effect in the Illinois IPPS on January 18, 1994 (per 89 IAC 152.150(c)). • DRG operating base rates and relative weights: based on what was in effect in the Illinois IPPS on June 30, 1995, less the portion of such rates attributed to the cost of medical education (per 89 IAC 152.150(d)). • DRG outlier payments: based on factors that were in effect on June 30, 1995 (per 89 IAC 152.150(f)). – The cost outlier threshold equals the 6/30/95 threshold multiplied by 1.40.
2.9		How often is the AP-DRG relative weight recalibrated?	• Originally, DRG relative weights were updated to reflect what was in effect in the Medicare IPPS 90 days prior to the date of admission (per 89 IAC 149.100(c)). Currently, DRG relative weights are based on what was in effect in the Illinois IPPS on June 30, 1995 (per 89 IAC 152.150(d)).
2.10		How often are conversion factors rebased, updated, or recalculated?	• Originally, conversion factors (called "DRG PPS base rate") were based on what was in effect in the Medicare IPPS 90 days prior to the date of admission (per 89 IAC 149.100(c)). Currently, DRG conversion factors are based on what was in effect in the Illinois IPPS on June 30, 1995 (per 89 IAC 152.150(d)).

ID	TASK	QUESTIONS	RESPONSES
2.11	5	What is the payment policy when billed charges are less than DRG payment?	• Payments for hospital inpatient services shall not exceed charges to the Department on a claim specific basis (per 89 IAC 152.150(e)). The payment limit does not apply to government owned or operated or children's hospitals.
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	**Day Outliers** (per 89 IAC 149.105): • A hospital is eligible for a day outlier payment if the patient's length of stay (including up to three administrative days) exceeds the day outlier threshold for the appropriate applicable DRG. – Days outliers are only eligible for DRGs 385 (neonate), 985 (died or transferred to another acute care facility), or DRG 456 (burns, transferred to another acute care facility), – The Outlier threshold is the DRG geometric mean length of stay plus the lesser of: ▪ three standard deviations, or ▪ the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, multiplied by: (Medicaid geometric length of stay)/ (average Medicare geometric mean length of stay) – Day outliers are reimbursed under a per diem methodology. Day outlier per diems are calculated by dividing the DRG PPS base rate by the mean length-of-stay for that DRG. Day outlier payments equal the covered days exceeding the outlier threshold multiplied by the day outlier per diem. **Cost Outliers** (per 89 IAC 149.105): • A hospital is eligible for a cost outlier payment if the claim's costs exceed the

ID	TASK	QUESTIONS	RESPONSES
			cost outlier threshold for the appropriate applicable DRG. – A claim's costs are estimated by multiplying a hospital's charges for covered services furnished to the client by the hospital specific cost-to-charge ratio. ▪ The hospital specific cost-to-charge ratio is computed at the beginning of each rate period. Please see the discussion of fixed payment per diem rate periods below (ID 3.8). ▪ Statewide cost-to-charge ratios are used when a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to lack of data. – The cost outlier threshold is based on the Medicare cost outlier cutoff threshold in effect 90 days prior to the date of admission. – A transferring hospital reimbursed under the DRG PPS is eligible for cost outlier payments if the hospital does not receive a day outlier payment. – Psych claims reimbursed under the DRG methodology are not eligible for outlier payments. **Day and Cost Outliers** (per 89 IAC 149.105(d)): • If a discharge qualifies for both a day and a cost outlier payment, the Department will pay the greater of the cost or day outlier payment amounts.
2.13		How often is the high outlier payment policy updated?	• Originally, the Department utilized the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission (per 89 IAC 149.105 (a)(2)(B)). Currently, the cost outlier threshold equals the threshold in effect in the Illinois IPPS on 6/30/95 multiplied by 1.40 (per 89 IAC 152.150(f)).
2.14		Are conversion factors and the high outlier policy updated concurrently?	• Neither being updated.

ID	TASK	QUESTIONS	RESPONSES
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	• Not incorporated.
2.16	6	What proportion of cases are paid using the outlier methodology?	• Information not provided.
2.17	6	Are there interim outlier payment strategies? What are they?	• Outlier interim payments are made for unusually long lengths of stay (per 89 IAC 149.150(d)(2)). – First Interim Payment: A hospital may request an interim payment after a Medicaid patient length of stay is at least 60 days. The first interim payment equals what the final discharge bill would have been if the patient was discharged, including outlier payments and services as of the last billed patient day. – Additional Interim Payments: A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill. Additional interim payment equal what the final discharge bill would have been if the patient was discharged, less previous interim payments.
2.18	6	What methods are used to pay for transfer cases?	• A hospital reimbursed under the DRG PPS that transfers to an inpatient hospital is paid a per diem rate for each day of the patient's stay in that hospital, capped at the full DRG prospective payment (per 89 IAC 149.25(b)). The per diem rate is determined by dividing the full DRG prospective payment rate by the geometric length of stay for the specific DRG to which the case is classified. • If a discharge is classified into DRGs 385 (neonate), 985 (died or transferred to another acute care facility), or DRG 456 (burns, transferred to another acute

ID	TASK	QUESTIONS	RESPONSES
			care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid the full prospective DRG payment. • A transferring hospital reimbursed under the DRG PPS may qualify for a high cost outlier payments. • A hospital or distinct part unit excluded from the DRG PPS that transfers to an inpatient hospital is reimbursed via the hospital-specific cost per diem based on hospital costs.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	• Information not provided.
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	• Standard transfer methodology only applies if a patient is transferred to a hospital or DPU. Transfers to a specialty hospital or long term care hospital are considered a discharge and readmission (per discussion with Department).
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	• Not used.
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	• Not used.
		Non-DRG Payment Methodologies	

Washington State Medicaid
Inpatient Hospital Rebasing Project
Illinois Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	• Not used.
3.2	3	For what services is the RCC methodology used?	• Not used.
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	• Not used.
3.4	3	How often are RCCs recalculated or updated?	• Not used.
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	• Operating costs for routine services follow Medicare allowable cost rules described in 42 CFR 413.53(b) (per 89 IAC 149.25(3)(A)).
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	• Per Medicare allowable cost rules, the additional cost from private room stays are removed during the calculation of the adult and pediatric cost per diem.
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• Fixed payment per case is not used. • Per diem payments are used for the following DRG-exempt hospitals (per 89 IAC 149.50(c-d)): – Rehabilitation hospitals and DPUs – Psychiatric hospitals and DPUs – Children's hospitals

ID	TASK	QUESTIONS	RESPONSES
			– Long-term stay hospitals – Sole Community Hospitals – University of Illinois at Chicago hospital – Cook County hospital
3.8	4	Describe the fixed payment per case or per diem methodology. How are payment levels determined?	**Fixed Per Diems for DRG-Exempt Hospitals:** • Base year operating payment per diems are calculated based on hospital operating costs (per IAC 148.260(a)): – The base year operating cost per diem is calculated by dividing Medicaid inpatient operating costs less capital and direct medical education for the two most recent cost report periods (available for at least 90% of reporting hospitals) by the hospital's Medicaid inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI). – The two trended operating cost per diems are then added together and divided by two to calculate the hospital's average operating cost per diem. – The average operating cost per diem is then divided by the indirect medical education (IME) factor in effect in the CMS Medicare IPPS 90 days prior to the admission. The resulting quotient is the final operating cost per diem for the base period. • Base year capital payment per diems are calculated based on hospital operating costs (per IAC 148.260(a)): – The base year capital cost per diem is calculated by dividing total capital costs for the two most recent cost report periods (available for at least 90% of reporting hospitals) by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

ID	TASK	QUESTIONS	RESPONSES
			– The two trended capital cost per diems are then added together and divided by two to calculate the hospital's average capital cost per diem. – The average capital cost per diems for all hospitals are sorted. Hospital per diem rates are capped at the 80th percentile. • Base year direct medical education per diems are calculated based on hospital direct medical education costs (per IAC 148.260(a)): – Direct medical education cost per diem is calculated by dividing total inpatient direct medical education costs for the two most recent cost report periods (available for at least 90% of reporting hospitals) by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI). – The two trended direct medical education cost per diems are then added together and divided by two to calculate the hospital's average direct medical education cost per diem. – The average direct medical education cost per diems for all hospitals are sorted. Hospital per diem rates are capped at the 80th percentile. • Originally, per diems payment amounts were rebased every three (3) years (per IAC 148.260(b-c)): – Per diems payment amounts were updated for inflation each rate period. ▪ The rate period began 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ended 90 days after any subsequent DRG PPS rate change under the federal Medicare Program. ▪ Per diems were updated as follows: ➢ Sole Community Hospitals: updated by trending the national hospital market basket price proxies (DRI) to the midpoint of the rate period. ➢ Other DRG exempt hospitals (except children's): updated by trending to

ID	TASK	QUESTIONS	RESPONSES
			the midpoint of the current rate period by utilizing the TEFRA price inflation factor. • Currently, per diem payments equal what was in effect in the Illinois IPPS on January 18, 1994, less the cost of medical education, except for Cook county and University of Illinois hospitals (per 89 IAC 152.200(b)). **Fixed Per Diems for Distinct Part Units:** • In the case of a distinct part unit, the Department divides the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period (per 89 IAC 148.270(b)). • The resulting quotient is multiplied by the hospital's total operating cost per diem (see Fixed Per Diems for DRG-Exempt Hospitals above). • The resulting product is added to the total hospital capital cost per diem, subject to the inflation adjustment (see Fixed Per Diems for DRG-Exempt Hospitals above). • The final distinct part unit payment rate shall be the lower of: – The Distinct Part Unit specific calculation, or – The total hospital cost per diem rate (see Fixed Per Diems for DRG-Exempt Hospitals above). • The hospital's final distinct part unit payment rate is not to be greater than three standard deviations above the mean distinct part unit payment rate. • Currently, per diem payments equal what was in effect in the Illinois IPPS on January 18, 1994, less the cost of medical education (per 89 IAC 152.200(b)).

ID	TASK	QUESTIONS	RESPONSES
			Capital Fixed Per Diems for DRG Hospitals • Capital costs for DRG claims are paid on a per diem add-on basis. Capital per diem add-ons are calculated as follows (per 89 IAC 149.150(c)): – Capital per diem add-ons are calculated by dividing total capital costs for the two most recent cost report periods (available for at least 90% of reporting hospitals) by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI). – The two trended capital cost per diems are then added together and divided by two to calculate the hospital's average capital cost per diem. – The average capital cost per diems for all hospitals are sorted. Hospital per diem rates are capped at the 80th percentile. • Currently capital per diem add-ons are based on what was in effect in the Illinois IPPS on January 18, 1994 (per 89 IAC 152.150(c)).
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	• Hospitals reimbursed on a per diem basis or for organ transplants are eligible for outlier payments for the following child patients (per 89 IAC 148.130(b)(2)): – Children under six years old at DSH hospitals. – Infants under one year old at non-DSH hospitals. • Per diem outlier payments are made for claims with total covered charges greater than or equal to the mean total covered charges plus one standard deviation (per 89 IAC 148.130(b)(3)). The outlier payment equals the difference of the following two components multiplied by 20% (per 89 IAC 152.200(d)(2)): – Total covered charges (less charges attributable to medical education) greater than or equal to one standard deviation above the mean multiplied by the hospital's cost to charge ratio.

ID	TASK	QUESTIONS	RESPONSES
			– The hospital's rate for services provided on the claim multiplied by the number of covered days on the claim. • Currently, per diem outlier payment components reflect what was in effect in the Illinois IPPS on January 18, 1994 (per 89 IAC 152.200(b)).
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	• Not applicable
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	• Issue was not relevant.
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	• Not applicable
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	• Not applicable
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	• Currently there are 49 CAHs, plus 3-4 "necessary providers" in process of certification (per discussion with Department).
4.2		Of total inpatient payments, what	• Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		percentage do CAH payments represent?	
4.3	3/9	What method does the state use to identify CAH hospitals?	• Critical Access Hospitals are designated by the Illinois Department of Public Health in accordance with 42 CFR 485, Subpart F (per 89 IAC 148.115(a)).
4.4	3/9	How does the state pay for inpatient CAH services?	• Critical Access Hospitals are paid under the DRG payment system. • Critical Access Hospitals qualify for lump sum Rural Critical Hospital Adjustment Payments (per 89 IAC 148.115).
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	**Rural Adjustment Payment** (per 89 IAC 148.115(b-c)): • The Rural Adjustment Payments are made to Critical Access Hospitals. The hospital-specific inpatient component is calculated as follows: – Total hospital inpatient payments are divided by total hospital inpatient days to derive an inpatient payment per day. – Total hospital inpatient charges are multiplied by the hospital's cost to charge ratio to derive total hospital inpatient cost. – Total hospital inpatient costs are divided by the total hospital inpatient days to derive a hospital inpatient cost per day. – Hospital inpatient payment per day is subtracted from the hospital inpatient cost per day to derive a hospital inpatient cost coverage deficit per day. The minimum result is zero. – Hospital inpatient cost coverage deficit per day is multiplied by the total inpatient days, to derive a total hospital specific inpatient cost coverage deficit. – The inpatient cost deficits for all qualifying hospitals are summed to determine an aggregate Rural Adjustment Payment base year inpatient cost

ID	TASK	QUESTIONS	RESPONSES
			deficit. • $7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services. – The total inpatient cost coverage deficit is added to a total outpatient cost coverage deficit to derive a total Rural Adjustment Payment base year deficit. – The inpatient pool allocation percentage is a calculated by dividing total inpatient cost deficit by the total Rural Adjustment Payment base year deficit. – An inpatient pool allocation is calculated by multiplying the inpatient pool allocation percentage by the $7 million pool. – An inpatient residual cost coverage factor is calculated by dividing the inpatient pool allocation by the total inpatient cost deficit. – The hospital specific inpatient cost coverage adjustment amount is calculated by multiplying the inpatient residual cost coverage factor by the hospital specific inpatient cost coverage deficit. – The hospital specific inpatient cost coverage adjustment amounts are paid at least on a quarterly basis.
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	• CAHs receive Rural Adjustment Payments. Please see the discussion of the quarterly payments above (ID 4.5).
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements?	• Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		If so, describe payment methodology.	
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	• Not applicable.
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	• Not applicable.
4.10	3/9	Does the State perform cost settlements for CAHs?	• Not applicable.
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	• Information not provided.
4.12	3/9	How many CAHs are in the state currently?	• See ID 4.1
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	• Information not provided.
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	• Information not provided.

ID	TASK	QUESTIONS	RESPONSES
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	• County-owned Level I or Level II trauma centers receive County Trauma Center Adjustment (TCA). Please see the discussion of TCA payments below (ID 5.6). • Non county-owned, non-University of Illinois Level I or Level II trauma centers receive Critical Hospital Adjustment Payments (CHAP). Please see the discussion of CHAP payments below (ID 5.6).
5.4	9	Does the State make special payments for Medicaid trauma care services?	• Both TCA and CHAP payments are based on Medicaid trauma admissions. Please see the discussion of Trauma payments below (ID 5.6).
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	• Both TCA and CHAP payments are lump sum by hospital. Please see the discussion of Trauma payments below (ID 5.6).
5.6	9	What is the specific methodology used to determine payment?	**County Trauma Center Adjustment (TCA)** (per 89 IAC 148.290(c)): • County hospitals recognized as Level I or Level II trauma centers receive an adjustment calculated as follows: – Trauma Center Fund for each quarter is divided by each eligible hospital's Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The resulting quotient is the County TCA adjustment per Medicaid trauma admission for the applicable quarter. – The county trauma center adjustment payments are not treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer. – The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.

ID	TASK	QUESTIONS	RESPONSES
			Critical Hospital Adjustment Payment (CHAP) (per 89 IAC 148.295(a)): • Illinois hospitals recognized as a Level I or Level II trauma center, excluding county owned hospitals and University of Illinois, receive CHAP payments. – Level I: ▪ Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions receive an adjustment of $21,365.00 per Medicaid trauma admission in the CHAP base period. ▪ Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions receive an adjustment of $14,165.00 per Medicaid trauma admission in the CHAP base period. – Level II Rural: rural hospitals recognized as a Level II trauma center receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period. – Level II Urban: urban hospitals recognized as Level II trauma centers receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period, provided the hospitals meet the following criteria: ▪ The hospital is located in a county with no Level I trauma center ▪ The hospital is located in a Health Professional Shortage Area (HPSA) and has a Medicaid trauma admission percentage at or above the mean of the individual facility values; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values.
5.7	9	How often are these payments made?	• County Trauma Center Adjustments (TCA) are made quarterly. Please see the discussion of TCA payments above (ID 5.6).

ID	TASK	QUESTIONS	RESPONSES
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	• Critical Hospital Adjustment Limitations (per 89 IAC 148.295(f)): : Hospitals are not eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I or a Level II trauma center as required for the adjustment. In these instances, the adjustments calculated are pro-rated, as applicable, based upon the date that the Trauma status ceased.
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	• Medicaid trauma admissions are defined by principal diagnosis code (per 89 IAC 148.295(g)(9).
5.10	9	What are these specific diagnosis or procedure codes?	• ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99 (per 89 IAC 148.295(g)(9).
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	• Payment adjustments are made for Trauma levels I and II. Please see the discussion of trauma payments above (ID 5.6).
5.12	9	How have the volume of trauma care services and Medicaid trauma care	• Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		payments changed over time?	
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	• Information not provided.
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	• Information not provided.
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	• Information not provided.
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	• The IAC does not distinguish between border and non-border out-of-state hospitals. Instead, it distinguishes between participating and non-participating hospitals. A nonparticipating out-of-state hospital provides fewer than 100 Illinois Medicaid days annually, does not elect to be reimbursed under the DRG Prospective Payment System, and does not file an Illinois Medicaid cost report (per 89 IAC 149.50(c)(5)).
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	• Participating out-of-state hospitals are reimbursed under the DRG system. New participating hospitals receive a per diem rate. • Nonparticipating out-of-state hospitals are reimbursed under the per diem methodology.
6.3		If the payment methodologies used to pay border hospitals are not different,	• Not applicable

ID	TASK	QUESTIONS	RESPONSES
		are border hospitals paid a discounted rate?	
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	• Not applicable
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	• Not applicable
7.2		What percentage of hospitals are included in the State's selective contracting program?	• Not applicable
7.3	8	What services are subject to selective contracting?	• Not applicable
7.4	8	What are the selective contracting payment approaches to IP services?	• Not applicable
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	• Not applicable
7.6	8	If the state uses an RCC method, is payment limited by customary	• Not applicable

ID	TASK	QUESTIONS	RESPONSES
		charges?	
7.7	8	Is a facility-wide RCC used or departmental RCCs?	• Not applicable
7.8	8	What is the source of the RCCs?	• Not applicable
7.9	8	How often are the RCCs used for payment updated?	• Not applicable
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	• Not applicable
8.2	8	Describe IP Centers of Excellence programs?	• Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	• Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	• Not applicable

ID	TASK	QUESTIONS	RESPONSES
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	• Not applicable
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	• Not applicable
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	• Yes. Please see the discussion of psych per diem payments above (ID 3.8).
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	• Psychiatric DPUs and hospitals are paid under the per diem methodology. Please see the discussion of psych per diem payments above (ID 3.8).
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	• No.
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	• The following hospital types are paid a psych per diem, regardless of diagnosis: – Psychiatric Hospitals (per 89 IAC 149.50(c))

ID	TASK	QUESTIONS	RESPONSES
			▪ Hospitals primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and ▪ Hospitals enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program. – Psychiatric Distinct Part Units (per 89 IAC 149.50(d)) • Acute hospitals are paid for psych services under the DRG system.
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	• Standard prospective DRG payment. Psych claims paid under the DRG methodology are not eligible for outlier payments (per 89 IAC 149.105(a)(4)(A)).
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	• No.
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	• Yes. Children's hospitals are paid under the per diem methodology (per 89 IAC 149.50(c)).
10.2		If not, does the state provide higher payment rates to children's hospitals?	• Not applicable

Washington State Medicaid
Inpatient Hospital Rebasing Project
Illinois Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	• 190,000 recipients are enrolled in Managed Care (per discussion with Department). • The Medicaid Managed Care program is a voluntary program that operates in 6 counties: Cook, Madison, Perry, Randolph, St. Clair and Washington. The department contracts with Managed Care Organizations (MCOs) to provide health services to managed care enrollees. Three HMOs and one MCCN provide health services for Medicaid and KidCare participants. Participants may enroll in managed care by contacting one of the MCOs (per Illinois Department of Healthcare and Family Services Managed Care Website).
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	• Information not provided.
		State Demographics	
12.1		How many Medicaid recipients do you have?	• 1,482,763 enrollees in December 2002 (Kaiser Family Foundation report)
12.2		What is your state's population?	• 12,653,544 (2003 U.S. Census Bureau estimate)

Washington State Medicaid
Inpatient Hospital Rebasing Project: Indiana Survey Matrix

ID	TASK	QUESTION	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	Most inpatient claims are paid under AP-DRG version 18. Psychiatric, Rehab, and Burn claims are assigned DRGs but reimbursed a per diem. Long-term acute care providers receive a fixed per diem. Per diem reimbursement is further explained in 3.8. Multivesceral transplants are paid a percentage of cost.
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Information not provided.
1.3		How are the following services paid for?	**Neonate Services** (other than normal newborn) Standard DRG payment methodology is used based on AP-DRG assignment. **Transplant Services** Per IAC 1-10.5-3(j), the reimbursement methodology for all covered intestinal and multivisceral transplants shall be equal to ninety percent (90%) of reasonable cost, until such time an appropriate DRG as determined by the office can be assigned. **Rehab Services** Per IAC 1-10.5-3 (l) Level-of-care cases are categorized as DRG number 462.. , The DRG number represents rehabilitative care. **Psych Services** Per IAC 1-10.5-3 (l) Level-of-care cases are categorized as DRG numbers 424–428, 429 (excluding diagnosis code 317.XX–319.XX), 430–432, These DRG numbers represent psychiatric care. **HIV Services**

ID	TASK	QUESTION	RESPONSES
			Standard DRG payment methodology is used based on AP_DRG assignment.
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	All DRGs have weights.
1.5		What percentage of total payments do the following services represent?	Information not provided. Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ % AP-DRG low volume _____ %
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	Per 405 IAC 1-10.5-3 (s), Facility-specific, per diem medical education rates shall be based on medical education costs per day multiplied by the number of residents reported by the facility. In subsequent years, but no more often than every second year, the office will use the most recent cost report data that has been filed and audited by the office or its contractor to determine a medical education cost per day that more accurately reflects the cost of efficiently providing hospital services. For hospitals with approved graduate medical, per 405 IAC 1-10.5-3 (t), Medical education payments will only be available to hospitals that continue to operate medical education programs. Disproportionate share payments are reimbursed to qualifying hospitals in an aggregate sum which does not exceed the limits imposed by Federal law including hospital specific limits imposed by 42 U.S.C 1396r-4(g). The hospital specific limit is summarized in the following formula: HSL = (All costs for services provided to Medicaid patients, less the amount paid by Medicaid under Non-DSH payment provisions of the State Plan (i.e., Medicaid shortfall) + (All costs for services provided to uninsured patients, less any cash payments made by uninsured patients (i.e., Uninsured shortfall).
1.7		Of total inpatient payments, what percentage	

ID	TASK	QUESTION	RESPONSES
		do additional payments (for DSH and GME) represent?	
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	Total Hospital Revenues[1] 2001 $8.884,700,000 2002 $9,726,500,000 2003 $11,020,900,00
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?[2]	2001 $733,800,000 2002 $946,300,000 2003 $787,500,000
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	The Office of Medicaid Policy and Planning monitors CMI and routinely recalibrates DRG relative weights to maintain and manage the CMI.
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	Information not provided.
1.13	2	What have been the payment/ utilization/ methods for RCC claims?	Information not provided.
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	3M's AP_DRG Grouper V.18
2.2	3	How are the DRG[3] conversion factors determined (methods & variables)? Describe?	• Indiana pays for acute services via a prospective cost-based AP-DRG method that contains no form of year-end settlement. Claims/services paid under the DRG payment methodology consist of the following: DRG rate (relative weight x DRG base rate) + Capital Cost Payment (rate x DRG

[1] www.in.gov/isdh/regsvcs/acc/fiscal03/index.htm
[2] www.in.gov/isdh/regsvcs/acc/fiscal03/index.htm
[3] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTION	RESPONSES
			Average length of stay) + Medical Education Payment, if applicable (rate x DRG average length of stay) + Outlier Payment, if applicable • Claims/services paid under the Level of Care per diem methodology consist of the following: Level of Care per diem rate + Capital Costs per diem + Medical Education per diem, if applicable + Outlier Payment, if applicable (burn care only) • AP-DRG Grouper: Indiana uses Version 18 of the AP-DRG Grouper. The AP-DRG mapper, a product of 3M, has been installed to allow providers to bill current ICD-9-CM codes despite using a different version of the AP-DRG grouper. The mapper converts current ICD-9-CM codes to the appropriate codes used by Version 18. • DRG base rate: The DRG base rate is the payment rate used to reimburse hospitals for both routine and ancillary costs associated with inpatient care. The Statewide base rate is determined using hospital cost reports and paid claims data. The DRG rate is determined by a fixed statewide base rate, which is the rate per IHCP stay multiplied by the relative weight: Statewide Base Rate x Relative Weight = DRG Rate The DRG base rate for children's hospitals is 120 percent of the statewide base amount for DRG services.
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	No
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	Per 405 IAC 1-10.5-3 (r), Medical education rates shall be prospective, hospital-specific per diem amounts. The medical education payment amount for stays reimbursed under the DRG methodology shall be equal to the product of the medical education per diem rate and the average length of stay for the DRG. Payment amounts for medical education for stays reimbursed under the level-of-care methodology shall be equal to the medical education per diem rate for each covered day of care. IME costs are not considered in

ID	TASK	QUESTION	RESPONSES
			GME payments nor is there a separate Medicaid IME payment made to Indiana Medicaid hospitals.
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	No
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	No, but a statewide cost to charge ratio is used to calculate outlier payments, when applicable. (Provider Manual)
2.7	3	What method was used to establish relative weights?	The average cost of a DRG divided by the average cost of all DRGs creates the weight. (Provider Manual)
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	Per 405 IAC 1-10.5-3 Relative weights are reviewed by the office and adjusted no more often than annually by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights are not made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate is evaluated individually to determine whether an adjustment to the relative weights should be made. DRG average length of stay values and outlier thresholds are revised when relative weights are adjusted. The office includes the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights. Such costs occurring within three (3) calendar days of an inpatient admission are not eligible for outpatient reimbursement under 405 IAC 1-8-3. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day. Base amounts are reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services.
2.9		How often is the AP-DRG relative weight recalibrated?	• Per 405 IAC 1-10.5-3(g) Relative weights will be reviewed by the office and adjusted no more often than annually by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may

ID	TASK	QUESTION	RESPONSES
			change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals.
2.10		How often are conversion factors rebased, updated, or recalculated?	• Per 405 IAC 1-10.5-3 (h) Base amounts will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services.
2.11	5	What is the payment policy when billed charges are less than DRG payment?	• Per 405 IAC 1-10.5-3(c), payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the lower of billed charges or the sum of the DRG rate, the capital rate, the medical education rate, and, if applicable, the outlier payment amount.
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	• The DRG outlier payment methodology is as follows, per the Indiana Provider Manual: – The state of Indiana defines a DRG outlier case as an IHCP stay that exceeds a predetermined threshold, defined as greater of twice the DRG or $34,425. The outlier threshold amount is effective for claims incurred on or after November 1, 2003. Day outliers (IHCP days that exceed a predetermined threshold) are not reimbursed under the DRG outlier payment policy. Under a DRG hybrid reimbursement system, the need for an outlier policy is significantly reduced, because cases that traditionally are classified as outliers, such as burn, psychiatric, and rehabilitative care, are reimbursed under the LOC component. The hybrid system, however, does not completely eliminate the need for appropriate outlier policies and reimbursement rates. Outlier payments are available for all qualifying cases reimbursed under the DRG system. – To determine the outlier payment amounts, costs per IHCP stay are calculated by multiplying a hospital-specific cost-to-charge ratio by allowed charges. The payment is a percentage of the difference between the prospective cost per stay and the outlier threshold indicated above. The percentage, or marginal cost factor, has been determined at 60 percent. Hospitals are notified individually of the specific cost-to-charge ratios that must be used to determine outlier payments for DRGs and the LOC system (burn only). Cost-to-charge ratios are calculated only during rebasing

ID	TASK	QUESTION	RESPONSES
			and recalibration periods, except for new providers. • Level of care Per Diem outlier payment methodology is as follows, per the Indiana Provider Manual: – Under the LOC system, outlier payments are made for burn cases that exceed established thresholds. The state of Indiana defines a LOC cost outlier as an IHCP hospital day with a cost per day that exceeds twice the burn rate. • To determine the outlier payment amounts, costs per IHCP stay are calculated by multiplying a hospital-specific cost-to-charge ratio by allowed charges. The outlier payment is a percentage of the difference between the prospective cost per day and the outlier threshold for each covered day of care. The percentage, or marginal cost factor, is 60 percent. The total payment is the sum of LOC rate, outlier payment, if applicable, capital rate, and medical education, if applicable, for each covered day of care.
2.13		How often is the high outlier payment policy updated?	Per 405 IAC 1-10.5-3(g), DRG average length of stay values and outlier thresholds will be revised when relative weights are adjusted.
2.14		Are conversion factors and the high outlier policy updated concurrently?	Per 405 IAC 1-10.5-3(g), DRG average length of stay values and outlier thresholds will be revised when relative weights are adjusted.
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	Outlier payments are generally not a consideration in conversion factor determination.
2.16	6	What proportion of cases are paid using the outlier methodology?	Information not provided.
2.17	6	Are there interim outlier payment strategies? What are they?	No, all claims are paid on a per-case basis. No interim payments are made. However, due to the long stays typically occurring in long-term acute care hospitals, these providers are exempt from DRG reimbursement and receive per diem payments to allow for better cash flow during long stays.
2.18	6	What methods are used to pay for transfer cases?	Per 405 IAC 1-10.5-3(x), special payment policies shall apply to certain transfer cases. The transferee, or receiving, hospital is paid according to the DRG methodology or level-of-

ID	TASK	QUESTION	RESPONSES
			care methodology. The transferring hospital is paid the sum of the following: (1) A DRG daily rate for each Medicaid day of the recipient's stay, not to exceed the appropriate full DRG payment, or the level-of-care per diem payment rate for each Medicaid day of care provided. (2) The capital per diem rate. (3) The medical education per diem rate. Certain DRGs are established to specifically include only transfer cases; for these DRGs, reimbursement shall be equal to the DRG rate. Per 405 IAC 1-10.5-3((y), hospitals will not receive separate DRG payments for Medicaid patients subsequent to their return from a transferee hospital. Additional costs incurred as a result of a patient's return from a transferee hospital are eligible for cost outlier reimbursement subject to subsection (v). The office may establish a separate outlier threshold or marginal cost factor for such cases.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	Information not provided.
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	Hospitals meeting the definition of an LTAC hospital are paid a daily rate, or per diem, for each day of care provided. The per diem is all-inclusive. No other payments are permitted in addition to the LTAC per diem.
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	Peer groups are used only for burn cases. Burn cases are divided into two groups, Burn/1 and Burn/2, based on the costs incurred by hospitals to treat burn patients. These rates have been developed to handle severe burn cases that call for specialized facilities and procedures. Burn/1 facilities have been identified based on the burn services provided in certified burn care facilities and the cost of those services.
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	For DRG payments, the DRG rate is determined by a fixed statewide base rate, For LOC payments, the cost per diem is calculated for each hospital in each of the four LOC groups. These per diem payments are based on the weighted median per diem cost, calculated based on the number of discharges.
		Non-DRG Payment Methodologies	

ID	TASK	QUESTION	RESPONSES
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	Not applicable.
3.2	3	For what services is the RCC methodology used?	An RCC is used only during the determination of outlier payments.
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	Hospitals are notified individually of the specific cost-to-charge ratios that must be used to determine outlier payments for DRGs and the LOC system (burn only). Cost-to-charge ratios are calculated using provider cost reports and are determined only during rebasing and recalibration periods. New in-state or border hospital providers receive the statewide median cost-to-charge ratio until a Medicaid cost report is received and audited.
3.4	3	How often are RCCs recalculated or updated?	Cost-to-charge ratios are calculated only during rebasing and recalibration periods, except for new providers.
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	Not Applicable
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	Not Applicable
3.7	4	Is a fixed payment per case methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• Long-term Acute Care (LTAC) providers, providers considered LTAC by Medicare and having average lengths of stay exceeding 24 days, receive per diem payments. The per diem rate for each provider is calculated by dividing the total payments the provider would have received under the DRG payment methodology by the total number of covered days. If insufficient claims detail is available for an eligible provider, the provider may receive the statewide median per diem. • Other claims/services are paid under the Level of Care per diem methodology consist of the following: LOC Rate + Capital Costs Payment + Outlier Payment, if applicable + Medical Education Costs Payment, if applicable • The following types of claims/services are paid under the Level of Care per diem

ID	TASK	QUESTION	RESPONSES
			methodology: – Certain burn cases – Psychiatric cases – Rehabilitation cases – Capital costs • Per Diem cases are classified as follows, per the Indiana Provider Manual: Claims are processed through the AP DRG Grouper to be classified into appropriate DRGs. Some claims are classified by specialty type, such as freestanding and distinct-part unit psychiatric and rehabilitation facilities. Claims classified into the following DRGs are excluded from the DRG system, and reimbursed under the LOC system as follows: – DRGs excluded for burn cases – 456 through 459, 472, and 821 through 828 – DRGs excluded for psychiatric cases – 424 through 432, DRG 429 excludes diagnoses 317XX through 319XX – DRGs excluded for rehabilitation cases – 462 • Per Diem rates are calculated as follows, per the Indiana Provider Manual: Level of care payment rates: LOC rates are established using costs derived from cost-to-charge ratio adjusted claims data for cases having the DRG numbers shown. The cost per diem is calculated for each hospital in each of the four LOC groups. These per diem payments are based on the weighted median per diem cost, calculated based on the number of discharges. Although there are three types of care, there are four LOC payment rates. The four LOC payment rates are as follows: – Psychiatric – Burn/1 – Burn/2 – Rehabilitation • Burn Per Diem rates are calculated as follows, per the Indiana Provider Manual: Burn cases are divided into two groups, Burn/1 and Burn/2, based on the costs incurred

ID	TASK	QUESTION	RESPONSES
			by hospitals to treat burn patients. These rates have been developed to handle severe burn cases that call for specialized facilities and procedures. Burn/1 facilities have been identified based on the burn services provided in certified burn care facilities and the cost of those services. These facilities consistently provide more intensive and more costly burn care than other Indiana hospitals and are the only hospitals eligible to bill and receive reimbursement at the Burn/1 rate. The certified Burn/1 facilities are the following: – Wishard Memorial Hospital – Clarian Health Partners – Saint Joseph's Hospital of Fort Wayne – University Medical Center (Louisville) All other hospitals are reimbursed at the Burn/2 rate. • The per diem rate for children's hospitals is 120 percent of the standard DRG of the statewide level-of-care rate. • Capital and Med Ed per diems are calculated as follows, per the Indiana Provider Manual: • The capital costs payment is a statewide per diem. Payment is based on the average length of stay for the assigned DRG for DRG-based payments and based on covered days for LOC-based payments. The calculation o the capital payment rate is occupancy (non-nursery beds) adjusted. The medical education costs payment is a provider specific per diem rate. Payment is based on the average length of stay for the assigned DRG for DRG-based payments and based on covered days for LOC-based payments.. . The calculation o the medical education payment rate is total medical education costs divided by total patient days.
3.8	4	Describe the fixed payment per case methodology? How are payment levels determined?	See previous answer

ID	TASK	QUESTION	RESPONSES
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	Burn cases are eligible for outlier payments. Outlier payments are 60% of the difference between estimated costs (charges X hospital –specific RCC) and the outlier threshold (burn payment x 2)
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	Not applicable
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	Certain cases have been excluded from the DRG rate methodology due to wide variances in length of stay and severity of resource consumption. (Provider manual)
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	DRG reimbursement maximizes efficiency within the provider community as DRG relative weights and base rates are frequently updated to reflect changes in treatment patterns and costs.
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	Not applicable
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	In March 2004, there were 21 CAHs out of approximately 131 total hospitals in Indiana.
4.2		Of total inpatient payments, what percentage do CAH payments represent?	A separate payment methodology is not in effect for CMS-defined critical access hospitals. The State does not recognize a CAH designation for payment purposes and does not track payments by that definition.
4.3	3/9	What method does the state use to identify CAH hospitals?	The State does not recognize a CAH designation for I/P hospital services payment purposes.
4.4	3/9	How does the state pay for inpatient CAH services?	The DRG and LOC payment methodologies apply to all general acute care hospitals
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care	Not applicable

ID	TASK	QUESTION	RESPONSES
		hospitals, and if so, how?	
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	No
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	No
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	The State does not recognize a CAH designation for I/P hospital services payment purposes. Indiana Medicaid hospitals are reimbursed PPS rather than cost-based, with no year-end settlements.
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	Cost-to-charge ratios are used in calculations of outlier payments, if applicable, and apply to all acute care hospitals. Cost information used in calculation of cost-to-charge ratios is updated when DRG relative weights and base rates are updated.
4.10	3/9	Does the State perform cost settlements for CAHs?	No
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	Increase
4.12	3/9	How many CAHs are in the state currently?	21 in 2004
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	Out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3) through 405 IAC 5-5-2(a)(4)
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	Hospitals that qualify as border hospitals are treated the same as in-state hospitals, for reimbursement purposes.

ID	TASK	QUESTION	RESPONSES
6.3		If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	No
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	No
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	No
7.2		What percentage of hospitals is included in the State's selective contracting program?	Not applicable
7.3	8	What services are subject to selective contracting?	Not applicable
7.4	8	What are the selective contracting payment approaches to IP services?	Not applicable
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	Not applicable
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	Not applicable
7.7	8	Is a facility-wide RCC used or departmental RCCs?	Not applicable
7.8	8	What is the source of the RCCs?	Not applicable
7.9	8	How often are the RCCs used for payment updated?	Not applicable
	8	**Centers of Excellence**	

ID	TASK	QUESTION	RESPONSES
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	No, although there are payment differentials for different level burn facilities
8.2	8	Describe IP Centers of Excellence programs?	Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	Not applicable
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	Not applicable
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	Not applicable
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	Yes, psychiatric services are paid a per diem rate.
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	Per diem rate
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	Information not provided.

ID	TASK	QUESTION	RESPONSES
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	DRG number
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	Per diem rate
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	No
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	Per 405 IAC 1-10.5-3(i), The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjusted cost per discharge greater than one (1) standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred twenty percent (120%) of the statewide base amount for DRG services.
10.2		If not, does the state provide higher payment rates to children's hospitals?	Yes. Please see 10.1
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	Information not provided.
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	Information not provided.

ID	TASK	QUESTION	RESPONSES
		State Demographics	
12.1		How many Medicaid recipients do you have?	739,902 (June 2004)[4]
12.2		What is your state's population?	6.2 million (2003)[5]

[4] www.statehealthfacts.org
[5] www.statehealthfacts.org

Washington State Medicaid
Inpatient Hospital Rebasing Project
Louisiana Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	Reimbursement for private inpatient hospital services is a prospective per diem rate for various peer groups based on 1991 cost data. Louisiana is considering implementing DRGs (targeted date on website is January 1, 2005). Exceptions to the per diem payment methodology are: • Transplant services – paid based on cost subject to a hospital-specific per diem limit that is based on each hospital's actual cost in the base year established for each type of approved transplant • Outlier policy that addresses catastrophic costs associated with services to children under six in a DSH hospital and for services to infants one year or under in all acute care hospitals (*Source:* Inpatient Hospital Services webpage -- http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=3476)

3.8	4	Describe the fixed payment per case methodology? How are payment levels determined?	• Hospitals are classified into one of five general peer groups or two specialty peer groups. Rates vary by peer group and have an operating, movable capital and fixed capital component. Payment rates are inflated annually in accordance with the State Plan contingent on the allocation of funds by the Legislature
			  ○ The payment rates for operating costs and movable equipment are according to a peer group capped amount.
			  ○ Fixed capital payment rates are based on a statewide capped amount.
			  ○ Medical education costs are reimbursed as a hospital-specific per diem amount.
			• Separate per diem for boarder babies that remain in the regular nursery of the hospital after the mother's discharges

ID	TASK	QUESTIONS	RESPONSES
			• Separate per diem rate for well babies that are discharged at the same time that the mother is discharged in private hospitals that perform more than 15000 Medicaid deliveries per year. This well baby per diem is the lesser of the hospital's actual costs or the boarder baby rate. • Separate per diems for burn unit, long term hospital care, children's hospitals, neuro and psych (*Source:* Inpatient Hospital Services webpage -- http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=3476)
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	Yes – Louisiana has a policy that addresses catastrophic costs associated with services to children under six in a DSH hospital and for services to infants one year or under in all acute care hospitals. To qualify for outlier status, a claim must have: • Covered charges that exceed 200 percent of the prospective payment • Covered charges that exceed $150,000 Louisiana pays outlier cases 100 percent of costs in excess of the prospective payment amount, and calculates cost-to-charge ratios based on the hospital's cost report period ending in SFY 2000. (*Source:* Hospital Outlier Payments webpage -- http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=3479)
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	***Pending State call – with Hurricane Katrina, I have not made any calls.***

Washington State Medicaid
Inpatient Hospital Rebasing Project
Nebraska Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	• CMS/Medicare DRG: Acute services (per 471 NAC 10-010.03B4). • Fixed payment per diem: Psychiatric and rehabilitation services (per 471 NAC 10-010.03D-E). • Fixed payment per case: Capital costs associated with acute services (per 471 NAC 10-010.03B8).
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Information not provided
1.3		How are the following services paid for?	**Neonate Services** (other than normal newborn) • A separate set of relative weights are developed for the treatment of neonates at a subspecialty care unit. Please see the discussion of relative weights below (ID 2.7). **Transplant Services** • Transplant services are paid under the standard inpatient acute payment methodology (per 471 NAC 10-005.20E1).

ID	TASK	QUESTIONS	RESPONSES
			Rehab Services • Rehab services are paid under the fixed payment per diem methodology. Please see the discussion of fixed payment per diems below (ID 3.8). **Psych Services** • Psych services are paid under the fixed payment per diem methodology. Please see the discussion of fixed payment per diems below (ID 3.8). **HIV Services** • 471 NAC chapter 10 does not exempt HIV or AIDS services from the DRG system.
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	• For DRGs with less than 10 cases, relative weights are borrowed from the Medicare relative weights that were effective for the Medicare program on October 1 of the preceding year (per 471 NAC 10-010.03B2).
1.5		What percentage of total payments do the following services represent?	Per discussion with Department: • Neonate Services 22.4% • Transplant Services 1.0% • Rehab Services 1.5% • Psych Services 6.5% • AP-DRG low volume N/A%
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts	**DSH** (per 471 NAC 10-010.03H2): • Disproportionate share hospital (DSH) payments are made one time each federal fiscal year following receipt of all required data by the Department.

ID	TASK	QUESTIONS	RESPONSES
		determined?	Payments determined for each federal fiscal year are considered payment for that year (not for the year from which proxy data used in the calculation was taken). To calculate payment, proxy data is used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination is applied. • DSH payments are made to hospitals which qualify for such a payment under one of the following pool distribution methods: – Basic DSH Payment (Pool 1): The basic DSH payment for eligible hospitals in Peer Groups 1, 2, 3, 5. – DSH Payment for Hospitals that Primarily Serve Children (Pool 2): DSH payments are made to the hospital that primarily serves children and has the greatest number of Medicaid days. – DSH Payment for State Owned Institutions for Mental Disease (IMD) (Pool 3): DSH payments are made to IMD hospitals and peer Group 4 hospitals. – Non-Profit Acute Care Teaching Hospital affiliated with a State-Owned University Medical College (Pool 4): DSH payments are made to nonprofit acute care teaching hospitals that have an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool is not eligible for payment under any other pool. – Reserve Disproportionate Share Payment (Pool 5): DSH payments are made for Nebraska private non-teaching, not-for-profit hospitals located in the Omaha urban area. **GME:** • **Hospitals/Services Paid Under DRG Methodology:**

ID	TASK	QUESTIONS	RESPONSES
			– Direct Medical Education Cost Payments (per 471 NAC 10-010.03B6a): ▪ Hospital payments for direct medical education costs are based on the Medical Assistance program's average cost per discharge for approved intern and resident programs. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year and adjusted annually for inflation using the CMS IPPS Price Index. ▪ To determine the direct medical education payment amount for each discharge, adjusted amounts are allocated to the Medicaid program based on the percentage of Medicaid patient days to total patient days in the base-year, and are divided by the number of base year Medicaid discharges and multiplied by 75%. ▪ Quarterly Direct Medical Education payment for services provided by NMMCP capitated plans are made based on discharge data provided by the plan(s). Payment is the number of discharges times the direct medical education cost payment. – Indirect Medical Education (IME) Cost Payments (per 471 NAC 10-010.03B6b): ▪ IME payments are made to hospitals that receive Medical Assistance direct medical education payments, and qualify for indirect medical education payments from Medicare. IME payments are a DRG add-on, calculated by multiplying an IME factor by the sum of the operating cost payment amount and the outlier payment amount times 72.64%. ▪ The IME factor is calculated as follows: [{1+(Number of Interns and Residents/Available Beds)}^0.405-1] 1.35 Base rates are adjusted by the applicable IME factor to exclude estimated IME costs.

ID	TASK	QUESTIONS	RESPONSES
			– Out-of-State hospitals: the Department may allow IME or direct medical education payments to out-of-state hospitals at a negotiated per discharge rate (per 471 NAC 10-010.03J). • **Hospitals/Services Reimbursed Under Per Diem Methodology:** – Direct medical education costs for hospitals/services reimbursed under the per diem methodology are reimbursed under a per diem add-on. Please see the discussion of the fixed payment per diem methodology below (ID 3.8).
1.7		Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	• Per FFY 2002 Form CMS 64: Medicaid Inpatient Fee-for-Service expenditures = $139,003,657 Medicaid DSH expenditures = $7,407,902
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	• Information not provided.
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	• Percentage increase in average monthly Medicaid recipients of inpatient care (per discussion with Department): FYE 2001 – 10.54% FYE 2002 – 9.57% FYE 2003 – 6.55% FYE 2004 – 2.20% FYE 2005 – 7.11%

ID	TASK	QUESTIONS	RESPONSES
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	• Percentage increase in inpatient fee-for-services payments (per discussion with Department): FYE 2001 – 8.85% FYE 2002 – 12.11% FYE 2003 – 8.48% FYE 2004 – 2.28% FYE 2005 – 6.10%
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	• Information not provided.
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	• Information not provided.
1.13	2	What have been the payment/utilization/methods for RCC claims?	• Information not provided.
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	• CMS DRG Grouper version is updated annually (per discussion with Department). Version 23 will be effective 10/1/05.

ID	TASK	QUESTIONS	RESPONSES
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	• DRG conversion factors are called "Peer Group Base Payment Amounts." Conversion factors are peer group specific (per 471 NAC 10-010.03B4). – Peer group base payment amounts are calculated as a percentage of the weighted median of case mix adjusted hospital-specific base year operating cost per discharge within a peer group. The median is then inflated to the midpoint of the rate year using the MBI. The peer group inflated median is then multiplied by one of the following percentages: ▪ Metro acute care hospitals: 85% ▪ Other urban acute care hospitals: 100% ▪ Rural acute care hospitals: 100% • The case mix adjusted hospital-specific base year operating cost per discharge is calculated as follows (per 471 NAC 10-010.03B3): – Data is extracted from base year Medicare cost reports. ▪ If a hospital files more than one Medicare cost report during calendar year, the Department uses the one which covers at least nine months or the greatest period of time. ▪ For any hospital which files Medicare cost reports for more than one reporting period ending during a calendar year but does not file a cost report covering a period of at least nine months, the computation rates are based on aggregate data from all cost reports filed for reporting periods ending during that calendar year. The Department may utilize cost report data that is not final-settled in instances where a final-settled Medicare cost report for a hospital is not available.

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
			– Operating costs are calculated as follows: ▪ Routine service costs - Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed costs. ▪ Inpatient ancillary service costs - Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. ▪ Total hospital-specific base year operating costs amounts are equal to the sum of Medicaid routine service costs and Medicaid inpatient ancillary service costs, less the building and fixtures portion of capital-related costs and direct medical education costs. ▪ Hospital-specific base year operating costs are divided by the hospital's base year case-mix index and the number of base year Medicaid discharges, and if applicable, the hospital's indirect medical education factor.
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	• Inpatient hospital reimbursement is based on peer group. One of the major criteria for the 6 different peer groups is whether a hospitals is in an urban or rural setting. Please see the discussion of hospital peer groups below (ID 2.21).
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	• Hospital-specific case-mix adjusted base year operating cost per discharge is divided by a hospital's indirect medical education factor. Please see the discussion of conversion factors above (ID 2.2).

ID	TASK	QUESTIONS	RESPONSES
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	• Not applicable
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	• No. Out-of-state hospitals are reimbursed for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. Please see the discussion of out-of-state reimbursement below (ID 6.2).
2.7	3	What method was used to establish relative weights?	• DRG relative weights are Nebraska specific, and are calculated as follows: – Two sets of weights are developed for DRGs for treatment of neonates (per 471 NAC 10-010.03B1a). Hospitals are reimbursed using the weight that reflects the setting for neonate treatment. ▪ One set is developed from charges associated with treating neonates in a subspecialty care unit for some portion of their hospitalization in hospitals meeting the criteria for providing subspecialty care. ▪ The second is developed from charges associated with treating neonates in hospitals that do not meet subspecialty care criteria. – Nebraska-specific weights are calculated from Medicaid charge data using the following calculations (per 471 NAC 10-010.03B2): ▪ Determine the Medicaid charges for each discharge. ▪ Remove all psychiatric, rehabilitation, Medicaid capitated plans, and Critical Access Hospital discharges. ▪ Determine the arithmetic mean Medicaid charges per discharge for each DRG by dividing the sum of all Medicaid charges for each DRG by the number of discharges. ▪ Determine the statewide arithmetic mean Medicaid charges per discharge

ID	TASK	QUESTIONS	RESPONSES
			by dividing the sum of all charges for all relevant discharges in the State by the number of discharges. ▪ For DRGs with 10 or more cases, divide the DRG arithmetic mean charges per discharge for each DRG by the statewide arithmetic mean charges per discharge to determine the Nebraska-specific relative weight for each DRG. ▪ For DRGs with less than 10 cases, relative weights will be borrowed from the Medicare relative weights that were effective for the Medicare program on October 1 of the preceding year. ▪ Adjust the relative weights so that the average of all discharges equals 1.0.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	• Originally, relative weights were calculated using all applicable discharges for a single year for a period from January 1, through December 31, for the calendar year ending 2 years prior to the effective date of the recalibration. Statistical outliers which exceeded the average mean charges value by three standard deviations are excluded from the calculations (per 471 NAC 10-010.03B2). • Currently relative weights are the same as what was in effect in the Nebraska IPPS on July 1, 2001 (per 471 NAC 10-010.03B2).
2.9		How often is the AP-DRG relative weight recalibrated?	• Relative weights have not been updated since July 1, 2001 (per 471 NAC 10-010.03B2).
2.10		How often are conversion factors rebased, updated, or recalculated?	• Conversion factors have not recently been rebased; instead conversion factors are updated by an inflation factor. The most recent rate updates were as follows (per 471 NAC 10-010.03B11): – Effective for the rate period beginning July 1, 2003, the peer group base

ID	TASK	QUESTIONS	RESPONSES
			payment amount and the direct medical education payment amount will be inflated using the CMS IPPS Price Index. Effective September 1, 2003, the peer group base payment amount in effect for the rate period ending June 30, 2003 shall be reduced by 3.15% and remain in effect until June 30, 2004. The peer group base payment amount and the direct medical education payment amount will be inflated using the CMS IPPS Price Index for the rate period beginning July 1, 2004.
2.11	5	What is the payment policy when billed charges are less than DRG payment?	• The Department pays the lesser of billed charges or allowable payment on a case-by-case basis (per 471 NAC 3-002.02F).
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	• Cost Outlier Payment Amounts are calculated as follows (per 471 NAC 10-010.03B5): – Outliers payments are made for approved discharges meeting or exceeding Medicaid criteria for cost outliers for each DRG. – Discharges qualify as cost outliers when the cost of services exceeds the outlier threshold. • Outlier threshold: the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $50,000. • Cost of services: calculated by multiplying the hospital-specific cost-to-charge ratio determined from the base year cost report times the allowed charges. – Cost outlier payment is 60% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 67.5%.

ID	TASK	QUESTIONS	RESPONSES
2.13		How often is the high outlier payment policy updated?	• No outlier payment updates are specified in 471 NAC chapter 10.
2.14		Are conversion factors and the high outlier policy updated concurrently?	• Not outlier payment updates are specified in 471 NAC chapter 10.
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	• Outlier claims are not removed during the calculation of cost per discharge (per discussion with Department). Please see the discussion of conversion factors above (ID 2.2).
2.16	6	What proportion of cases are paid using the outlier methodology?	• Inpatient fee-for-service outlier payments out of total inpatient fee-for-service payments including per diem payments (per discussion with Department - figures in millions): FYE 2002 – $12.5 out of $135 (9%) FYE 2003 – $23.2 out of $161 (14%) FYE 2004 – $24.8 out of $172 (14%)
2.17	6	Are there interim outlier payment strategies? What are they?	• Interim payments for long-stay patients are available upon request (per 471 NAC 10-010.03B15). The NAC states that hospitals may receive partial reimbursement, but it does not specify the interim payment methodology – A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days. – Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital must submit a final billing for payment upon discharge of the patient. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final

ID	TASK	QUESTIONS	RESPONSES
			payment will be reduced by the amount of the interim payment.
2.18	6	What methods are used to pay for transfer cases?	**Hospitals Paid via DRG Methodology** (per 471 NAC 10-010.03B11): • Transferring hospitals: The transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100% of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG. • Hospitals receiving a transferred patient: payment is the full DRG payment and, if applicable, cost outlier payment.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	• Information not provided.
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	• Not treated as transfers (per discussion with Department). Treated as discharge and admit.
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	• Hospitals are split into 6 peer groups (per 471 NAC 10-010.03A): 1. Metro Acute Care Hospitals (DRG): Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare. 2. Other Urban Acute Care Hospitals (DRG): Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;

ID	TASK	QUESTIONS	RESPONSES
			3. Rural Acute Care Hospitals (DRG): All other acute care hospitals; 4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals (Per Diem): Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; 5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals (Per Deim): Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and 6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	• Conversion factors are based on the median of case mix adjusted hospital-specific base year operating costs per discharge within each peer group. Please see the discussion of conversion factors above (ID 2.2).
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	• Not applicable.
3.2	3	For what services is the RCC methodology used?	• Not applicable.
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	• Not applicable.

ID	TASK	QUESTIONS	RESPONSES
3.4	3	How often are RCCs recalculated or updated?	• Not applicable.
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	• Allowable cost rules follow Medicare statutes and regulations (per 471 NAC 10-010.03A).
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	• Per Medicare allowable cost rules, the additional cost from private room stays are removed during the calculation of the adult and pediatric cost per diem. • Hospitals are reimbursed for bed and board the same amount for inpatient services whether the client has a private room, a semiprivate room, or ward accommodations (per 471 NAC 10-002.02).
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• Fixed payment per case: Capital costs related to services reimbursed under DRG payment methodology. Please see the discussion of the fixed payment per case below (ID 3.8). • Fixed payment per diem: Psychiatric and rehabilitation services. Please see the discussion of the fixed payment per diem below (ID 3.8).
3.8	4	Describe the fixed payment per case or per diem methodology. How are payment levels determined?	**Fixed Payment Per Case:** • Capital-Related Cost Payments (per 471 NAC 10-010.03B8): Capital costs related to services reimbursed under the DRG system are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the DRG. – The Medicaid capital related per diem costs are calculated from base year

ID	TASK	QUESTIONS	RESPONSES
			Medicare cost reports as follows (per 471 NAC 10-010.03B7): 1. Routine service capital-related costs - Medicaid routine service capital related costs are calculated by allocating total hospital routine service capital-related costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed capital-related costs. 2. Inpatient ancillary service capital-related costs - Medicaid inpatient ancillary service capital-related costs are calculated by multiplying an overall ancillary capital-related cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary capital-related cost-to-charge ratio is calculated by dividing the sum of the capital-related costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. 3. Total capital-related costs are equal to the sum of Medicaid routine service capital-related costs and Medicaid inpatient ancillary service capital-related costs. 4. Building and fixtures capital-related costs are calculated by multiplying total capital-related costs times a percentage determined by dividing total hospital building and fixtures costs by total hospital capital costs. 5. The capital-related per diem cost is calculated by dividing Medicaid building and fixtures capital-related costs by the sum of base year Medicaid acute care and bassinet patient days. – Effective September 1, 2003, capital costs are calculated as 96.85% of the peer group weighted median cost per day. **Fixed Payment Per Diem**: • Psychiatric Services (per 471 NAC 10-010.03D): payments for psych services

ID	TASK	QUESTIONS	RESPONSES
			are made on a per diem basis. – All psychiatric services, regardless of the type of hospital providing the service, are reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. The per diem will be the sum of - 1. The peer group base payment per diem rate; 2. The hospital-specific capital per diem rate; and 3. The hospital's direct medical education per diem rate, if applicable. – Payment for each discharge equals the per diem times the number of approved patient days. Payment is made for the day of admission, but not the day of discharge. Mental health and substance abuse services provided to clients enrolled in the NMMCP for the mental health and substance abuse benefits package will be reimbursed by the plan. – Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year. Adjusted base year costs are then divided by patient days for all psychiatric free-standing hospitals and Medicare-certified distinct part units. Hospital per diem amounts are weighted by patient days, and the peer group median is determined. – Calculation of Hospital-Specific Capital Per Diem Rate: Capital related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem. – Calculation of Direct Medical Education Per Diem Rate: Hospital specific direct medical education costs reflect MA average cost per patient day for

ID	TASK	QUESTIONS	RESPONSES
			approved interns and residents. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year, and adjusted for inflation using the MBI. To determine the direct medical education payment amount paid for each patient day, adjusted amounts are divided by the number of base year Medicaid psychiatric patient days and multiplied by 75%. – Payment for Hospital Sponsored Residential Treatment Center Services: Payments for hospital sponsored residential treatment center services are made on a prospective per diem basis. Since July 1, 2001, this rate has been determined by the Department and is based on historical and future reasonable and necessary cost of providing services. • Rehabilitation Services (per 471 NAC 10-010.03E): payments for rehab services are made on a per diem basis: – All rehabilitation services, regardless of the type of hospital providing the service, are reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem is the sum of - 1. The hospital-specific base payment per diem rate; 2. The hospital-specific capital per diem rate; and 3. The hospital's direct medical education per diem rate, if applicable. – Payment for each discharge equals the per diem times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge. – Calculation of Hospital-Specific Base Payment Amount: The hospital specific base payment per diem is calculated as 100% of the median of the hospital

ID	TASK	QUESTIONS	RESPONSES
			specific base year operating costs for the base year, adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year. Adjusted base year costs are then divided by patient days for all rehabilitation free-standing hospitals and Medicare-certified distinct part units. – Calculation of Hospital-Specific Capital Per Diem Rate: Capital related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem.
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	• 471 NAC chapter 10 does not discuss high outlier payments for DRG-exempt hospitals/services.
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	• Not applicable
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	• Not applicable
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	• Not used
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	• Not used

Washington State Medicaid
Inpatient Hospital Rebasing Project
Nebraska Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	• 60 CAHs out of 101 total hospitals (per discussion with Department)
4.2		Of total inpatient payments, what percentage do CAH payments represent?	• 6% (per discussion with Department)
4.3	3/9	What method does the state use to identify CAH hospitals?	• A Critical Access Hospital is defined as a hospital licensed as a Critical Access Hospital by the Department of Health and Human Services Regulation and Licensure and certified for participation by Medicare as a Critical Access Hospital (per 471 NAC 10-010.03A).
4.4	3/9	How does the state pay for inpatient CAH services?	• Critical Access Hospitals (CAHs) are cost-settled. Please see the discussion of CAH payment methodology below (ID 4.8).
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	• Critical Access Hospitals (CAHs) are cost-settled. Please see the discussion of CAH payment methodology below (ID 4.8).
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	• Not applicable.

ID	TASK	QUESTIONS	RESPONSES
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	• Managed care for acute services is only in urban areas without CAHs.
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	• Payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement. – Routine costs are determined by extracting routine cost per diems from the Medicare cost report, then multiplying the per diems by covered days. – Ancillary costs are determined by extracting cost center-specific ancillary CCRs from the Medicare cost report, then multiplying the CCRs by allowable charges. • The following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers (per 471 NAC 10-010.03F). – Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services would be covered if furnished to hospital inpatients.
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	• Not applicable.
4.10	3/9	Does the State perform cost settlements for CAHs?	• Critical Access Hospitals (CAHs) are cost-settled. Please see discussion of CAH payment methodology above (ID 4.8).
4.11	3/9	Has the State observed any decreases or increases in the number of critical	• Yes. In 1999, the Department anticipated 5 CAHs. Now there are 60.

ID	TASK	QUESTIONS	RESPONSES
		access hospitals statewide? What are the reasons for changes in CAH status?	
4.12	3/9	How many CAHs are in the state currently?	• See ID 4.1.
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	• Not applicable.
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	• Not applicable.
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	• Not applicable.
5.4	9	Does the State make special payments for Medicaid trauma care services?	• Not applicable.
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	• Not applicable.
5.6	9	What is the specific methodology used	• Not applicable.

ID	TASK	QUESTIONS	RESPONSES
		to determine payment?	
5.7	9	How often are these payments made?	• Not applicable.
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	• Not applicable.
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	• Not applicable.
5.10	9	What are these specific diagnosis or procedure codes?	• Not applicable.
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	• Not applicable.
5.12	9	How have the volume of trauma care services and Medicaid trauma care payments changed over time?	• Not applicable.
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	• Not applicable.
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund	• Not applicable.

ID	TASK	QUESTIONS	RESPONSES
		used for the uninsured)?	
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	• Not applicable.
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	• 471 NAC Chapter 10 does not distinguish between border and non-border out-of-state hospitals.
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	• The out-of-state payment methodology is as follows (per 471 NAC 10-010.03J): – Out-of-state hospitals are reimbursed for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are: 1. Metro Acute Care Hospitals: Hospitals with 100 or more acute care beds located in Metropolitan Statistical Area (MSAs) as designated by Medicaid. 3. Rural Acute Care Hospitals: All other acute care hospitals; 4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state which the hospital is located and distinct parts as defined in the NAC. 5. Rehabilitation Hospitals and Distinct Part Units: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in these regulations. – Peer groups 2 (Other Urban Acute) and 6 (Critical Access Hospitals) are not included in 471 NAC 10-010.03J.

ID	TASK	QUESTIONS	RESPONSES
			– Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. Capital costs are currently 96.85% of the peer group weighted median cost per day. The cost-to-charge ratio applied to outlier claims is the peer group average. – Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. – The Department may allow payments or indirect medical to out-of-state hospitals for direct education costs at a negotiated per discharge rate.
6.3		If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	• Not applicable.
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	• Not applicable.
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	• Not applicable

ID	TASK	QUESTIONS	RESPONSES
7.2		What percentage of hospitals are included in the State's selective contracting program?	• Not applicable
7.3	8	What services are subject to selective contracting?	• Not applicable
7.4	8	What are the selective contracting payment approaches to IP services?	• Not applicable
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	• Not applicable
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	• Not applicable
7.7	8	Is a facility-wide RCC used or departmental RCCs?	• Not applicable
7.8	8	What is the source of the RCCs?	• Not applicable
7.9	8	How often are the RCCs used for payment updated?	• Not applicable
	8	**Centers of Excellence**	

ID	TASK	QUESTIONS	RESPONSES
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	• Not applicable
8.2	8	Describe IP Centers of Excellence programs?	• Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	• Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	• Not applicable
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	• Not applicable
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	• Not applicable
		IP Psychiatric Services	

ID	TASK	QUESTIONS	RESPONSES
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	• Yes. Please see the discussion of fixed payment per diem above (ID 3.8).
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	• Inpatient psychiatric services are paid on a per diem basis. Please see the discussion of fixed payment per diem above (ID 3.8).
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	• No.
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	• Inpatient psychiatric services are paid on a per diem basis regardless of hospitals setting. Claims are paid based on provider number.
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	• Acute hospitals are not reimbursed for psych DRGs (per discussion with Department).
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	• No (per discussion with Department).
		Children's Hospitals	

ID	TASK	QUESTIONS	RESPONSES
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	• 471 NAC chapter 10 does not exempt children's hospitals from the standard DRG methodology.
10.2		If not, does the state provide higher payment rates to children's hospitals?	• Hospitals that primarily service children receive DRG operating base rates calculated at 120% of the peer group base payment amount for peer group 1 (Metro Acute Hospitals) (per 471 NAC10-010.03B4a). A hospital qualifies for this group when it is located in Nebraska and is certified as meeting the criteria, as a children's hospital, for exclusion from the Medicare Prospective Payment System (PPS).
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	• The following recipients are required to enroll in Medicaid managed care (per managed care contract section 3.2.1): – Clients participating in the Aid to Dependent Children Program Grant/Medical. This includes clients participating in the Medical Assistance Programs for Children (i.e., Ribicoff), Medical Assistance for Children (MAC), School Age Medical (SAM) and Kids Connection. – Clients participating in the Aid to Aged, Blind, and Disabled Program Grant/Medical. – Clients participating in the Child Welfare Payments and Medical Services Program (i.e., IV-E, Non-IV-E, Former Wards, Subsidized Guardianship cases). • Recipients are enrolled through Enrollment Broker Services (EBS), which is a contracted entity that completes initial client marketing, education, and outreach; enrollment activities; health assessment; health services

ID	TASK	QUESTIONS	RESPONSES
			coordination; public health; nursing; Helpline services; client advocacy; and EBS satisfaction surveys (per managed care contract section 5.1)
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	• Payment for NHC Services (per managed care contract section 7.47): The Department pays a Per Member Per Month (PMPM) administrative fee to the PCCM Network Administrator and a service/case management fee to the PCP for each enrolled client for each month of NHC coverage. The monthly fee does not include payment for services in the Basic Benefits Package - claims payment is the responsibility of the Department on a fee-for-service basis. – The PMPM service/case management fee for the PCP is contracted at $2.00. The contract shall include the amount agreed upon by the Contractor and the Department for the Contractor's administrative responsibilities for the PCCM Network. At no time shall the rates be adjusted prior to the end of contract year 2. The payment shall be set for each two (2) year period and negotiated for each subsequent two-year period.
		State Demographics	
12.1		Ho many Medicaid recipients do you have?	• 205,546 enrollees in December 2002 (Kaiser Family Foundation report)
12.2		What is your state's population?	• 1,739,291 (2003 U.S. Census Bureau estimate)

Washington State Medicaid
Inpatient Hospital Rebasing Project
North Carolina Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	▪ CMS/Medicare DRG ▪ Per diem payment for psychiatric (patients in DRGs 424 – 437 & 521 – 523) and rehabilitation (patients in DRG 462) inpatient services provided in Medicare recognized distinct part units or other beds in general acute care hospitals. Per diem payment also applies for all services provided by specialty psychiatric and rehabilitation hospitals. ▪ In addition to the regular Medicaid payments that hospitals receive through claims processing, the State makes lump sum supplemental payments periodically throughout the year. These supplemental payments are intended to cover a portion of hospitals' Medicaid deficits from the regular Medicaid payment, i.e. they are based on the difference between hospitals' costs and their amounts they receive through the DRG and per diem payment methodologies. Non-state public hospitals' supplemental payments are 100 percent of their Medicaid deficits, but the non-federal share of these supplemental payments is covered by these hospitals certified public expenditures (CPEs). Thus these hospitals receive cash supplemental payments equal to the federal share (63.63 percent for 2005) of the Medicaid deficits. Private hospitals receive supplemental payments for a lower percentage than the public hospitals of their Medicaid deficits. Private teaching hospitals also receive an additional supplemental payment. ▪ Retrospective cost reimbursement for state-operated psychiatric hospitals, and the primary affiliated teaching hospitals for the University of North Carolina Medical Schools, and proposed for CAHs. Interim payments are made using the DRG and per diem methods using rates that are to

ID	TASK	QUESTIONS	RESPONSES
			approximate each of these hospitals' actual costs and then are settled to the actual costs from cost reports.
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Distribution of inpatient payments paid through claims processing ▪ AP-DRG or CMS/Medicare DRG - 91 % ▪ Percent of billed charges - NA ▪ Fixed payment per case – NA ▪ Fixed per diem - 9 % ▪ Other Method - NA % Distribution of total inpatient payments including supplemental payments ▪ DRG – 72% ▪ Fixed per diem – 7% ▪ Supplemental – 21% Distribution of total inpatient payments including supplemental & DSH payments ▪ DRG – 51% ▪ Fixed per diem – 6% ▪ Supplemental – 15% ▪ DSH – 28%
1.3		How are the following services paid for?	**Neonate Services** (other than normal newborn) North Carolina pays for these are a DRG basis but replaces DRGs 385 – 391 in the

ID	TASK	QUESTIONS	RESPONSES
			Medicare Grouper Version 12 with the following: 385 Neonate, died or transferred, length of stay less than 3 days 801 Birth weight less than 1,000 grams 802 Birthweight 1,000 – 1,499 grams 803 Birthweight 1,500 – 1,999 grams 804 Birthweight >=2,000 grams, with Respiratory Distress Syndrome 805 Birthweight >=2,000 grams premature with major problems 810 Neonate with low birthweight diagnosis, age greater than 28 days at admission 389 Birthweight >= 2,000 grams, full term with major problems 390 Birthweight >= 2,000 grams, full term with other problems or premature without major problems 391 Birthweight >= 2,000 grams, full term without complicating diagnoses **Transplant Services** Based on DRGs for in-state hospitals. Negotiated rates for out-of-state hospitals on a case-by-case basis. **Rehab Services** Paid on a per diem basis; the per diem rate is the lesser of the hospital's actual cost trended to the rate year or the calculated median rate of all hospitals providing rehabilitation services as derived from the most recent filed cost reports. Out-of-state hospitals are paid at the median rate. **Psych Services** Paid on a per diem basis. North Carolina is closing and consolidating some of its state-owned psychiatric hospitals and as part of this Mental Health Reform, in 2005 the State rebased its per diem rate for psychiatric services using 2003 or the

ID	TASK	QUESTIONS	RESPONSES
			most recent as-filed cost reports. (CMS is reviewing a SPA that will make these rebased rates effective as a July 29, 2005). Prior to this rebasing, hospital psych per diem rates had been the lesser of their actual cost as originally set in 1995 or the median rates, updated for inflation in some years. Analysis of the rebased rates showed that some hospitals would be paid significantly less than they had been using the 1995-based rates. Therefore, in the SPA that the State submitted to CMS, it decided that for hospitals that routinely provide psychiatric services and whose base rate trended forward to SFY 2005 is less than their rate as of October 1, 2004 (based on the original rate set in 1995 and trended forward to 2004), the base rate would be set at the October 1, 2004 amount and trended forward in subsequent years. The base rate for hospitals that do not routinely provide psychiatric services and for out-of-state hospitals is set at the median rate for all other psychiatric hospitals. **HIV Services** No special provision; paid the applicable DRG rate for whichever DRG an inpatient with HIV groups to.
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	For DRGs lacking sufficient volume, the State sets relative weights using the North Carolina Medical Data Base Commission's discharge abstract file covering all inpatient services delivered in North Carolina hospitals. For DRGs in which there are an insufficient number of discharges in the Medical Data Base Commission data set, the State sets relative weights based upon the published DRG weights for the Medicare program. For the Neonatal categories in which North Carolina use its own hybrid of the CMS DRG Grouper, there has always been sufficient volume of Medicaid cases.
1.5		What percentage of total payments do the following services represent?	Neonate Services - 8% of all DRG cases; percent of payments not available

ID	TASK	QUESTIONS	RESPONSES
			Transplant Services - .03% of all DRG cases; percent of payments not available Rehab Services - 1 % of payments made through claims processing Psych Services - 9 % of payments made through claims processing AP-DRG low volume - NA
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	Hospitals operating Medicare approved graduate medical education programs receive DRG/per diem payment rate adjustments that reflect the reasonable direct and indirect costs of operating those programs. The State defines reasonable direct medical education costs consistent with the base year cost per resident methodology described in 42 CFR 413.86 (the State's source for the number of resident FTEs is the S schedules from hospitals' Medicare cost reports) . The ratio of the aggregate approved amount for graduate medical education costs at 42 CFR 413.86(d)(1) to total reimbursable costs (per Medicare principles) is the North Carolina Medicaid direct medical education factor. The direct medical education factor is based on information supplied in the 1993 cost reports and the factor is updated annually soon as practicable after July 1 based on the latest cost reports filed prior to July 1. The indirect medical education factor is equal to the Medicare indirect medical education factor in effect on October 1 each year. Hospitals operating an approved graduate medical education program have their DRG unit values increased by the sum of the direct and indirect medical education factors. North Carolina has several kinds of DSH payments and enhanced payments that are in addition to DRG payments. These payments are terminating Sept. 30, 2005 (as required by CMS) and are to be replaced with different kinds of DSH and enhanced payments that are part of a SPA the State has submitted to CMS. The major change in the proposed SPA is to eliminate the IGT and replace it with a CPE program (CPEs were already being used for the non-federal share of non-state public hospitals' supplemental payments). The SPA proposes to make DSH

ID	TASK	QUESTIONS	RESPONSES
			payments to public and CAHs only in general, for a portion of their unreimbursed uninsured costs. For private hospitals that formerly received DSH payments, the SPA proposes to keep them whole with new DSH-like Medicaid enhanced payments that will be based on unreimbursed uninsured costs, but subject to the Medicare UPL. Virtually all hospitals will receive Medicaid enhanced payments for a portion of their Medicaid deficits, i.e. the difference between their Medicaid costs and regular Medicaid DRG/per diem payment with teaching hospitals receiving higher DSH (public teaching hospitals) or enhanced (private teaching hospitals) payments, as they have since 1996.
1.7		Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	For SFY 2004, GME payments were 10 percent of DRG- and per diem-related payments (i.e. excluding supplemental payments)
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	Hospital inpatient charges, including psych and rehab, increased at a compound rate of 5 percent per year between SFY 2000 and 2004; on a per discharge basis, they rose at compound rate of 8 percent per year over the same period.
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	Medicaid inpatient discharges, including psych and rehab, increased at a compound rate of 3.8 percent per year between SFY 2000 and 2004
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	For DRG and per diem payments made through claims processing, i.e. excluding DSH and Medicaid Supplemental Payments, Medicaid payments per discharge increased at a compound rate of 1.6 percent per year between SFY 2000 and 2004.
1.11	2	Have there been any significant changes in Case Mix Indices in recent	No

ID	TASK	QUESTIONS	RESPONSES
		years? Explain?	
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	9 percent of DRG payments in SFY 2004
1.13	2	What have been the payment/utilization/methods for RCC claims?	Not applicable
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	North Carolina's Medicaid hospital payment program operates on the federal fiscal year. North Carolina uses the Medicare/CMS grouper, except for neonates (see response to 1.3 above) and changes each year to the version Medicare is using, for example, for its 2006 rate year that will begin Oct. 1, the State will use version 23. However, a SPA that CMS is currently reviewing, would change this so that the State would use the Grouper version that is one year behind the version Medicare uses. This is to allow the State sufficient time to recalibrate the DRG weights and install the new grouper and weights by Oct. 1 to eliminate the retroactive adjustments they now have to make.
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	The unit value (i.e. the DRG payment rate for a DRG with a relative weight of one) or conversion factor has not been recalculated since the DRG system was implemented in 1995. The unit value for each hospital was determined by converting charges on claims for discharges occurring during calendar year 1993, to estimated costs by applying the hospital specific cost to charge ratio from each

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
			hospital's submitted Medicaid cost report for hospital fiscal years ending during that period or the most recent cost report available. Cost estimates were standardized by removing direct and indirect medical education costs. All cost estimates were adjusted to a common 1994 fiscal year and inflated to the 1995 rate year and then reduced by an expected 8 percent decline in days times each hospital's per diem cost for routine services. Each hospital's cost per discharge was divided by its casemix index and then these casemix adjusted costs per discharge were reduced by 7.2 percent to account for outlier payments. The DRG Unit Value for hospitals at or below the 45th percentile in this ranking is set using 75% of the hospital's own adjusted cost per discharge and 25% of the cost per discharge of the hospital at the 45th percentile. The DRG Unit Value for hospitals ranked above the 45th percentile was set at the cost per discharge of the 45th percentile hospital. The DRG unit value for new hospitals and hospitals that did not have a Medicaid discharge in the base year was set at the cost per discharge of the 45th percentile hospital. The DRG unit value for out-of-state hospitals was set at the 45th percentile. The unit values are updated for inflation as determined by North Carolina Office of State Budget, Planning and Management and approved by the North Carolina General Assembly. The DRG unit values have increased 29 percent between 1995 and 2005. In recent years the updates have been: » 2003 – 0% » 2004 – 0% » 2005 – 3.4% » 2006 – 0%
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	No

ID	TASK	QUESTIONS	RESPONSES
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	Direct and indirect medical education costs from teaching hospitals' cost reports were removed from these hospitals' Medicaid costs in calculating the DRG unit value or conversion factor.
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	North Carolina only negotiates rates for transplants with out-of-state hospitals and these negotiations are done on a case-by-case basis.
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	North Carolina pays out-of-state hospitals on the same bases, i.e. DRG and per diem for psych and rehab, as for in-state hospitals, but the conversion or DRG unit value for them was the originally calculated 45th percentile of all in-state hospitals' costs per case. Psych and rehab services that are paid on the same per diem basis as for in-state hospitals, but at the median rate, rather than the lower of their actual costs and the median.
2.7	3	What method was used to establish relative weights?	The State sets relative weights for each DRG based on recent historical claims submitted for Medicaid recipients, converting charges on each claim to costs by applying the hospital-specific RCC ratio from each hospital's submitted Medicaid cost report. Cost estimates are standardized by removing direct and indirect medical education costs at the appropriate rates for each hospital. Relative weights are calculated as the ratio of the average cost in each DRG to the overall average cost for all DRGs combined. Prior to calculating these averages, low statistical outlier claims are removed, and the costs of claims identified as high statistical outliers are capped at the statistical outlier threshold. The State employs criteria for identifying statistical outliers that are expected to result in the highest number of DRGs with statistically stable weights. The State employs a statistically valid methodology to determine whether there

ID	TASK	QUESTIONS	RESPONSES
			are a sufficient number of recent claims to establish a stable weight for each DRG. For DRGs lacking sufficient volume, the State sets relative weights using DRG weights generated from the North Carolina Medical Data Base Commission's discharge abstract file covering all inpatient services delivered in North Carolina hospitals. For DRGs in which there are an insufficient number of discharges in the Medical Data Base Commission data set, the State sets relative weights based upon the published DRG weights for the Medicare program. When relative weights are recalculated, the overall average CMI is be kept constant.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	The State as not rebased the DRG unit values/conversion factors since 1995 when they were originally set. The State recalibrates the DRG weights each year according to the methodology described in 2.7 above.
2.9		How often is the AP-DRG relative weight recalibrated?	Relative weights are recalculated when the new version of the DRG Grouper is installed by the State to be effective October 1 of the rate year.
2.10		How often are conversion factors rebased, updated, or recalculated?	The State as not rebased the DRG unit values/conversion factors since 1995 when they were originally set.
2.11	5	What is the payment policy when billed charges are less than DRG payment?	No
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	The State recognizes cost outliers and for patients under six only, day outliers. Both kinds of outlier payments are subject to retrospective review on a case-by-case basis. Discharges that qualify for both cost outlier and day outlier payments are paid the greater of the cost outlier or day outlier payment. <u>Cost Outliers</u> » A cost outlier threshold is set for each DRG at the time DRG relative weights

ID	TASK	QUESTIONS	RESPONSES
			are calculated, using the same information used to establish those relative weights. The cost threshold is the greater of $25,000 or mean cost for the DRG plus 1.96 standard deviations. » Billed charges (excluding non-covered services and services not reimbursed under the inpatient DRG methodology, such as professional fees), are converted to cost using a hospital-specific total facility RCC (different than the Medicare cost report total facility RCC because cost that Medicare excludes, such as labor & delivery are added back). The cost to charge ratio excludes medical education costs. » The cost outlier payment is 75 percent of the costs above the threshold as calculated on an individual claim by multiplying allowable charges by the hospital-specific inpatient total facility RCC. <u>Day Outliers</u> » Day outlier payments apply only for children under six at DSHs and children under age one at non-DSHs. » A day outlier threshold is set for each DRG at the time DRG relative weights are calculated, using the same information used to establish the relative weights. The day outlier threshold is the greater of 30 days or the arithmetical mean LOS for the DRG plus 1.5 standard deviations. » Days beyond the outlier threshold are paid at a per diem rate that is 75 percent of the hospital's DRG payment rate divided by the DRG average LOS.
2.13		How often is the high outlier payment policy updated?	Annually effective for Oct. 1
2.14		Are conversion factors and the high	Yes, in years when the DRG unit value/conversion factor is updated for inflation,

ID	TASK	QUESTIONS	RESPONSES
		outlier policy updated concurrently?	but as noted in 2.2. above, in many years these values/conversion factors have not been updated for inflation.
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	In determining the original DRG unit value or conversion factor, the State reduced each hospital's casemix adjusted cost per discharge by 7.2 percent to account for outlier payments. These DRG unit values have not been rebased since they were originally calculated, but are updated in some years for inflation.
2.16	6	What proportion of cases are paid using the outlier methodology?	8.5 percent
2.17	6	Are there interim outlier payment strategies? What are they?	Outlier payments can be made on interim bills that hospitals submit to the State's fiscal agent; when the hospital submits a final bill, there is a settlement to what the outlier payments should be.
2.18	6	What methods are used to pay for transfer cases?	When a patient is transferred between hospitals, the transferring hospital receives a pro-rated payment equal to the normal DRG payment multiplied by the patient's actual length of stay divided by the geometric mean length of stay for the DRG. When the patient's actual length of stay equals or exceeds the geometric mean length of stay for the DRG, the transferring hospital receives full DRG payment. Transfers are eligible for cost outlier payments. The final discharging hospital shall receive the full DRG payment. Hospital discharges are considered transfers if the patient's DRGs is 14, 113, 209, 210, 211, 236, 263, 264, 429, or 483 and the patient is discharged to: » a hospital or distinct part hospital unit excluded from the DRG reimbursement system; or » a skilled nursing facility; or » home under a written plan of care for the provision of home health services

ID	TASK	QUESTIONS	RESPONSES
			from a home health agency and those services begin within three days after the date of discharge.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	2 percent
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	When a patient has a medically appropriate transfer from a medical or surgical bed to psychiatric or rehabilitative distinct part unit within the same hospital, or to a specialty hospital the admission to the distinct part unit or the specialty hospital is recognized as a separate service and is paid under the regular per diem methodology for psych and rehab services.
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	North Carolina has no peer groups. When the DRG system was implemented, the State developed the teaching hospital DSH payment, which is based on teaching hospitals' unreimbursed uninsured costs and was intended to compensate for the fact that these hospitals' Medicaid per discharge costs exceeded the 45th percentile, the level at which their DRG conversion factors was capped.
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	Yes, for hospitals whose casemix adjusted cost per discharge were below the 45th percentile when the DRG unit value or conversion factor was originally set, their DRG unit value was set using 75 percent of the hospital's own adjusted cost per discharge and 25 percent of the cost per discharge at the 45th percentile.
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	For setting the DRG cost outlier thresholds and making cost outliers payments only.

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ID	TASK	QUESTIONS	RESPONSES
3.2	3	For what services is the RCC methodology used?	No inpatient services.
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	Not applicable
3.4	3	How often are RCCs recalculated or updated?	Not applicable
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	Not applicable
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	Not applicable
3.7	4	Is a fixed payment per case methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	Not applicable
3.8	4	Describe the fixed payment per case methodology? How are payment levels determined?	Not applicable
3.9		Is there a high outlier policy for fixed	No

ID	TASK	QUESTIONS	RESPONSES
		payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	Not applicable
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	The original DRG system does not adequately classify psychiatric and rehabilitation patients for purposes of defining homogenous patient groupings with respect to resource utilization. Thus, the State chose to pay for these services on a per diem basis for the same reason that CMS excluded them from the original Medicare PPS. The State considered implementing a system based on Medicare's Inpatient Psychiatric Facility PPS as part of the Mental Health Reform initiative that will shift Medicaid patients from state psychiatric institutions to community hospitals. However, the analysis showed that many hospitals would be big winners and losers under such a system. Since the State needs the community hospitals' cooperation in accepting patients from the state institutions, it decided to remain with the per diem payment system for now. However, the State expects that after the community hospitals has some experience in serving the patients who are now cared for in state institutions, they will pressure the State for a payment system that accounts for differences in patient acuity, such as Medicare's Inpatient Psychiatric Facility PPS.
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	Not applicable

ID	TASK	QUESTIONS	RESPONSES
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	Not applicable
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	There are 124 hospitals in the State including 8 that are owned and operated by the North Carolina Department of Mental Health. Of the 116 non-state non-psych hospitals, 18 or 16 percent are CAHs. Two more hospitals are expected to become CAHs soon. The Dept. of Rural Health has determined that 25 of the State's hospitals could be designated as CAHs.
4.2		Of total inpatient payments, what percentage do CAH payments represent?	.9 percent of total inpatient payments including supplemental and DSH.
4.3	3/9	What method does the state use to identify CAH hospitals?	The North Carolina Dept. of Rural Health has established criteria for CAHs based on CMS criteria and state-defined criteria. The state-defined criteria include the income level of the county in which the hospital is located. The Dept. of Rural Health has determined that 25 of the State's hospitals could be designated as CAHs.
4.4	3/9	How does the state pay for inpatient CAH services?	Through Sept. 30, 2005, the same as for other hospitals, except CAHs have been eligible for a special DSH payment, the effect of which, when combined with a supplemental payment, is to pay them 100 percent of their Medicaid costs. Under the proposed SPA the State has submitted to CMS, all CAHs would be paid 100 percent of their allowable costs, according to Medicare principles, on a retrospective cost basis subject to settlement based on their audited cost reports.

ID	TASK	QUESTIONS	RESPONSES
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	See answer in 3/9
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	See answer in 3/9
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	No. However, the State has and will continue to have a DSH payment specifically for hospitals that contract with Medicaid managed care organizations, the effect of which is to pay the hospitals the same percentage of their costs for serving Medicaid HMO patients as they receive for FFS Medicaid patients. Thus, if a CAH reports charges for Medicaid HMO patients, and meets the federal DSH criteria, it receives the Medicaid HMO DSH payment. But this is not exclusive to CAHs. However, none of the State's CAH contacts with Medicaid HMOs.
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	See answer 3/9
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	Not applicable
4.10	3/9	Does the State perform cost settlements for CAHs?	As noted in 3/9, it will if CMS approves the SPA that the State has submitted.
4.11	3/9	Has the State observed any decreases or increases in the number of critical	There has been an increase in the number of CAHs over the past few years; the Dept. of Rural Health has been proactive in helping hospitals get CAH

ID	TASK	QUESTIONS	RESPONSES
		access hospitals statewide? What are the reasons for changes in CAH status?	designation, because they would be in jeopardy of closing otherwise.
4.12	3/9	How many CAHs are in the state currently?	There were 18 CAHs for rate year 2005, and two more hospitals are expected to become CAHs soon. The Dept. of Rural Health has determined that 25 of the State's hospitals could be designated as CAHs.
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	Not applicable
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	Not applicable
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	Not applicable
5.4	9	Does the State make special payments for Medicaid trauma care services?	Not applicable
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	Not applicable

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ID	TASK	QUESTIONS	RESPONSES
5.6	9	What is the specific methodology used to determine payment?	Not applicable
5.7	9	How often are these payments made?	Not applicable
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	Not applicable
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	Not applicable
5.10	9	What are these specific diagnosis or procedure codes?	Not applicable
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	Not applicable
5.12	9	How have the volume of trauma care services and Medicaid trauma care payments changed over time?	Not applicable
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	Not applicable

ID	TASK	QUESTIONS	RESPONSES
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	Not applicable
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	Not applicable
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	There is no distinction between out-of-state and border hospitals.
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	The State pays out-of-state providers using the same methods as for in-state hospitals. Out-of-state hospitals' costs per discharge were not used in setting the original DRG unit value, so out-of-state hospitals DRG unit values were set equal to the maximum value (at the 45th percentile). The State pays one Virginia hospital that provides NICU services at 60 percent of its charges. This was arranged many years ago under a litigation threat. Out-of-state hospitals do not receive payment adjustments for GME costs (either direct or indirect), but they are eligible for cost outlier payments. North Carolina makes DSH payments to out-of-state hospitals that qualify for DSH in their home states. In the past, the DSH payment was the percentage add-on to the per discharge or per diem payment that their home state paid, up to a cap of 5 percent. Under the proposed SPA that is before CMS, such DSH payments would be capped at a 2.5 percent add-on.
6.3		If the payment methodologies used to pay border hospitals are not different,	No

ID	TASK	QUESTIONS	RESPONSES
		are border hospitals paid a discounted rate?	
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	No
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	No
7.2		What percentage of hospitals are included in the State's selective contracting program?	Not applicable
7.3	8	What services are subject to selective contracting?	Not applicable
7.4	8	What are the selective contracting payment approaches to IP services?	Not applicable
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	Not applicable
7.6	8	If the state uses an RCC method, is payment limited by customary	Not applicable

ID	TASK	QUESTIONS	RESPONSES
		charges?	
7.7	8	Is a facility-wide RCC used or departmental RCCs?	Not applicable
7.8	8	What is the source of the RCCs?	Not applicable
7.9	8	How often are the RCCs used for payment updated?	Not applicable
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	No
8.2	8	Describe IP Centers of Excellence programs?	Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	Not applicable

ID	TASK	QUESTIONS	RESPONSES
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	Not applicable
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	Not applicable
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	Yes
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	Per diem payment for psychiatric (patients in DRGs 424 – 437 & 521 – 523) inpatient services provided in Medicare recognized distinct part units or other beds in general acute care hospitals. Per diem payment also applies for all services provided by specialty psychiatric hospitals. Paid on a per diem basis. North Carolina is closing and consolidating some of its state-owned psychiatric hospitals and as part of this Mental Health Reform, in 2005 the State rebased its per diem rate for psychiatric services using 2003 or the most recent as-filed cost reports. (CMS is reviewing a SPA that will make these rebased rates effective as of July 29, 2005). Prior to this rebasing, hospital psych per diem rates had been the lesser of their actual cost as originally set in 1995 or the median rates, updated for inflation in some years. Analysis of the rebased rates showed that some hospitals would be paid significantly less than they had

ID	TASK	QUESTIONS	RESPONSES
			been using the 1995-based rates. Therefore, in the SPA that the State submitted to CMS, it decided that for hospitals that routinely provide psychiatric services and whose base rate trended forward to SFY 2005 is less than their rate as of October 1, 2004 (based on the original rate set in 1995 and trended forward to 2004), the base rate would be set at the October 1, 2004 amount and trended forward in subsequent years. The rebased median rate that will be effective as of July 29, 2005 when CMS approves the SPA, is nearly 13 percent higher than the median rate in effect prior to July 29, 2005 ($544.58 vs. $483.55). The base rate for hospitals that do not routinely provide psychiatric services and for out-of-state hospitals is set at the median rate for all other psychiatric hospitals.
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	The State considered implementing a system based on Medicare's Inpatient Psychiatric Facility PPS as part of the Mental Health Reform initiative that will shift Medicaid patients from state psychiatric institutions to community hospitals. However, the analysis showed that many hospitals would be big winners and losers under such a system. Since the State needs the community hospitals' cooperation in accepting patients from the state institutions, it decided to remain with the per diem payment system for now. However, the State expects that after the community hospitals has some experience in serving the patients who are now cared for in state institutions, they will pressure the State for a payment system that accounts for differences in patient acuity, such as Medicare's Inpatient Psychiatric Facility PPS.
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	Patients in DRGs 424 – 437 & 521 – 523 that receive services in Medicare recognized distinct part units or other beds in general acute care hospitals. All patients in specialty psychiatric hospitals are considered psychiatric patients and the State pays for services to them at per diem rates.

ID	TASK	QUESTIONS	RESPONSES
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	For general acute care hospitals, as long as a patient's DRG is 424 – 437 or 521 – 523, the State pays the psych per diem rates regardless of whether the hospital has a distinct part psych unit. All patients in specialty psychiatric hospitals are considered psychiatric patients and the State pays for services to them at per diem rates.
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	No
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	No
10.2		If not, does the state provide higher payment rates to children's hospitals?	No, other than day outlier payments that is limited to services to patients under age six and one.
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	North Carolina's Medicaid managed care program is voluntary and it is only in one county.
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with	The HMOs and hospitals negotiate rates. But the State has and will continue to have a DSH payment specifically for hospitals that contract with Medicaid managed care organizations, the effect of which is to pay the hospitals the same percentage of their costs for serving Medicaid HMO patients as they receive for FFS Medicaid patients through regular and enhanced/supplemental Medicaid

ID	TASK	QUESTIONS	RESPONSES
		hospitals?	payments.
		State Demographics	
12.1		How many Medicaid recipients do you have?	1.5 million (SFY 2004 per DMA report)
12.2		What is your state's population?	8.4 million (2003 estimate)

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ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	Ohio pays for inpatient hospitals uses DRGs with the exception of the following providers/services (Ohio Administrative Code, 5101:3-2-07.1, effective June 1, 2004): ▪ Freestanding rehabilitation hospitals excluded from Medicare PPS ▪ Freestanding long-term hospitals excluded from Medicare PPS ▪ Hospitals providing rehab and long-term care services that are excluded from Medicare PPS ▪ Ohio hospitals that are owned and operated by health insuring corporations licensed by the Ohio Department of Insurance and which limit services to Medicaid recipients ▪ Cancer hospitals ▪ Selected transplant services – heart/lung and pancreas, liver/small bowel Payment for the excluded services/providers are based on reasonable costs.
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Information not provided. ▪ AP-DRG or CMS/Medicare DRG _____ % ▪ Percent of billed charges _____ % ▪ Fixed payment per case _____ % ▪ Fixed per diem _____ % Other Method _____ %

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ID	TASK	QUESTIONS	RESPONSES
1.3		How are the following services paid for?	**Neonate Services** (other than normal newborn) DRGs **Transplant Services** Ohio pays for transplants using DRG, with the exception of heart/lung, pancreas and liver/small bowel (Ohio Admin Code 5101:3-2-07.1, effective June 1, 2004), which are paid using reasonable cost reimbursement (Ohio Administrative Code 5101:3-2-22, effective January 1, 2005). Under reasonable cost reimbursement, Ohio makes interim payments using a historical cost-to-charge ratio, which are then reconciled to reasonable costs actually incurred during that time period. **Rehab Services** Reasonable costs (rehabilitation hospitals, and hospitals providing a combination of rehabilitation and long-term care services) **Psych Services** DRGs **HIV Services** DRGs
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	When ten or less claims grouped into a DRG, the department established relative weights taking into consideration the weights that previously were used for the DRG, as well as the DRG case mix (Ohio Administrative Code: 5101:3-2-073). The relative weights were established for these infrequent DRGs (Ohio has a listing of these DRGs in Appendix A to the Administrative Code cite). When ten or less claims grouped into a new DRG, the Department used relative weights current

ID	TASK	QUESTIONS	RESPONSES
			used by Medicare.
1.5		What percentage of total payments do the following services represent?	Information not provided. Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ % AP-DRG low volume _____ %
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	*DSH – the Hospital Care Assurance Program (HCAP)* Ohio's DSH program "HCAP" incorporates both intergovernmental transfers and provider tax funding. HCAP provides hospital services for persons whose income falls at or below 100 percent of the FPL and who are not Medicaid eligible (Ohio Senate Redbook for the Department of Jobs and Family Services, April 28, 2005). Under HCAP, Ohio assesses an amount based on hospital total facility costs and government hospitals make annual intergovernmental transfers to ODJFS. Assessments and intergovernmental transfers are made in periodic installments. Total spending for HCAP for 2006 and 2007 is approximately $575.1 million A June 15, 2004 Office of the Inspector General Report described Ohio's oversight and administrative of DSH limits and payments as "exemplary" although it also said that Ohio inappropriately paid for IMD services for individuals aged 22-64 and recommended that the State pay back $47 million in Federal funds. DSH Payments include (Ohio Administrative Code 5101:3-2-09, effective data July

ID	TASK	QUESTIONS	RESPONSES
			22, 2005): • *Payments to hospitals meeting the high Federal DSH definition* (hospital with a ratio of total Medicaid days plus MCP days to total facility days greater than the statewide mean ratio of total Medicaid days to total facility days plus one standard deviation) -- $41,441,812 total payments effective July 22, 2005. • *Payments from Medicaid indigent care pool* (calculated by looking at Medicaid shortfall and Title V costs) -- $90,810,067 total payments effective July 22, 2005. • *Payments from the disability assistance medical and uncompensated care pool* – payments equal to disability assistance medical costs and uncompensated care costs not covered by payments, subject to some limitations. No total $$ for the pool mentioned in Administrative Code. • *Rural and critical access payment pools* – CAHs receive a portion of a $4,000,000 pool based on Medicaid shortfall. Non-CAHs that are rural access hospitals receive additional payments. • *Children's hospital pool* – receive a portion of a $7,000,000 fund DSH funds from hospitals that exceed the hospital-specific DSH limits are put into a "Statewide residual payment pool" and distributed to hospitals that have not yet met their hospital-specific DSH limits. There is an additional DSH payment for psychiatric hospitals (Ohio Administrative Code 5101:3-2-10, effective date July 22, 2005).
1.7		Of total inpatient payments, what percentage do additional payments	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		(for DSH and GME) represent?	
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	Information not provided.
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	Information not provided.
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	Information not provided.
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	Information not provided.
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	Information not provided.
1.13	2	What have been the payment/utilization trends with respect to the following DRG groups? (DRGs Defined?)	Information not provided.
1.14	2	What have been the	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		payment/utilization/methods for RCC claims?	
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	Ohio uses the grouper distributed by Health Services, Incorporated, a software package used by Medicare during Federal Fiscal Year 1998 (Ohio Administrative Code, 5101:3-2-07.11, effective date June 1, 2004). *Note – later in the Code, there is a reference to DRG Version 15.0, which I assume is the same as the 1998 grouper.*
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	The conversion factor is equal to the average cost per discharge component. This component is calculated differently for different types of hospitals as follows (Ohio Administrative Code 5101:3-2-07, effective date August 21, 2003): • Children's hospitals --- 100 percent hospital-specific • Rural referral center hospitals – peer group average • Teaching hospitals – peer group average • Non-metropolitan statistical average area hospitals with less than 100 beds – peer group average • Non-metropolitan statistical average area hospitals 100 or more beds – peer group average • Metropolitan statistical average hospitals – peer group average – these hospitals are peer grouped on the basis of wage index categories

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
			• Out-of-state hospitals – Average cost per discharge that varies based on hospital type (teaching hospital, children's hospitals and all other). Ohio Administrative Code 5101:3-2-07.2 provides additional detail (effective data August 1, 2002). Ohio uses two source documents to calculate the average cost per discharge – ODHS 2930 "Cost Report" and the HCFA 2552-85. These documents reflect costs associated with the hospital's 1985 or 1986 fiscal year reporting period. *Adjustments to Costs as part of the Cost Per Discharge Calculation* • Remove cost of blood replaced by patient donors • Include PSRO/UR • Adjust costs for malpractice insurance • Remove direct and indirect cost of medical education • Remove capital-related costs • Remove the effects of wage differences for hospitals in the teaching hospital peer group • For teaching and children's hospitals, calculate an outlier set-aside (or, "outlier adjustment amount"). Subtract this from the cost per discharge for each peer group. • Adjust the cost per discharge for coding by dividing the average cost per discharge by 1.005. • Adjust the peer group average charge per discharge for the teaching hospital peer group using a wage factor – this wage factor is based on medical education costs and the labor portion of the Medicaid inpatient

ID	TASK	QUESTIONS	RESPONSES
			cost • Adjust costs for inflation using a Ohio-specific inflation factor (detailed description in Ohio Administrative Code) After multiplying the average cost per discharge by the DRG relative weight, Ohio adds in the following hospital allowances as applicable: education allowance for teaching hospitals, hospital-specific capital allowance for Ohio hospitals, and a single capital allowance for non-Ohio hospitals *Endnote 2 provides a detailed description of the conversion factor calculation from the Ohio Administrative Code*
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	Yes – the conversion factors are determined by peer groups, and these peer groups are, in part, based on geographic area – specifically (Ohio Administrative Code 5101:3-2-07, effective date August 21, 2003): • Rural referral center hospitals – peer group average • Non-metropolitan statistical average area hospitals with less than 100 beds – peer group average • Non-metropolitan statistical average area hospitals 100 or more beds – peer group average • Metropolitan statistical average hospitals – peer group average – these hospitals are peer grouped on the basis of wage index categories • Out-of-state hospitals – Average cost per discharge that varies based on hospital type (teaching hospital, children's hospitals and all other). Ohio Administrative Code 5101:3-2-07.2 provides additional detail (effective data August 1, 2002).

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ID	TASK	QUESTIONS	RESPONSES
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	*Graduate Medical Education, Including Indirect Medical Education* Ohio excluded graduate medical education and direct medical education costs from its conversion factor calculation. Ohio hospitals may receive a direct medical education allowance and an indirect medical education allowance, which Ohio adds to the DRG base price for teaching hospitals after multiplying the allowance by the DRG relative weight. Ohio Administrative Code 5101:3-2-07.7 provides the detailed calculations for these allowances, which is also found in Endnote #3. *Disproportionate Share Hospital* Ohio makes disproportionate share hospital payment separately from its DRG payments. Given the large size of its DSH program ($575.1 million in 2006 and 2007), it appears that these payments are a critical proportion of hospital Medicaid payments.
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	It does not appear that Ohio uses selective contracting
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	No, although there are differences in conversion factor calculations between in-state and out-of-state hospitals
2.7	3	What method was used to establish relative weights?	Generally speaking, Ohio determines the relative weight for a diagnostic category on its average charge compared to an average charge for all discharges. Ohio

ID	TASK	QUESTIONS	RESPONSES
			gives special consideration to psychiatric DRGs 425 and neonatal DRGs 385 to 390. Specifically: • DRG 386 (Extreme Immaturity or Respiratory Distress Syndrome): Ohio uses three subgroups with three different relative weights. These groups and relative weights are based on the ICD-9-CM codes and the level of the neonatal nursery *(more detail available in Ohio Administrative Code)*. Ohio calculates the geometric mean for each of these subgroups for purposes of relative weight calculation • DRG 387 (Prematurity with Major Problems): Ohio uses four subgroups with four different relative weights. These groups and relative weights are based on the infant's birthweight and the level of the neonatal nursery *(more detail available in Ohio Administrative Code)*. Ohio calculates the geometric mean for each of these subgroups for purposes of relative weight calculation • DRGs 388, 389, 390: Ohio calculated the geometric mean charge three times to determine a geometric mean charge specific to hospitals with a level I nursery, hospitals with a level II nursery, and hospitals with a level III nursery. For example, three geometric mean charges were calculated for DRG 388, one reflecting data from hospitals with a level I nursery; one reflecting data from hospitals with a level II nursery; and one reflecting data from hospitals with a level III nursery • DRGs 425 to 435: Ohio calculated two geometric mean charges for each DRG. One geometric mean charge was calculated using the charge for each case within these DRGs from hospitals which have a psychiatric unit distinct part. A second geometric

ID	TASK	QUESTIONS	RESPONSES
			mean charge was calculated for each DRG 425 to 435 using data from all other hospitals (hospitals which do not have a recognized psychiatric unit distinct part under Medicare). See Endnote 1 at the end of matrix for Ohio Administrative Code section related to the development of relative weights.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	• At the beginning of each State Fiscal Year, Ohio applies a projected inflation value (Ohio Administrative Code 5101:3-2-07.8, effective August 1, 2002). The Administrative Code also states that the State may choose the make a rules adjustment and rebase base-year costs or recalibrate the relative weights, or both. • If a reclassification of hospitals among peer groups occurs, Ohio will redetermine the peer group average cost per discharge component if such a redetermination will result in at least a two percent difference, negative or positive, in the peer group average cost per discharge amount Ohio Administrative Code 5101:3-2-07.8, effective August 1, 2002). *More detail available in Administrative Code*
2.9		How often is the AP-DRG relative weight recalibrated?	On an as-needed basis – the Ohio Administrative Code does not reference a particular timeframe
2.10		How often are conversion factors rebased, updated, or recalculated?	• At the beginning of each State Fiscal Year, Ohio applies a projected inflation value (Ohio Administrative Code 5101:3-2-07.8, effective August 1, 2002). The Administrative Code also states that the State may choose the make a rules adjustment and rebase base-year costs or recalibrate the relative weights, or both.

ID	TASK	QUESTIONS	RESPONSES
			• If a reclassification of hospitals among peer groups occurs, Ohio will redetermine the peer group average cost per discharge component if such a redetermination will result in at least a two percent difference, negative or positive, in the peer group average cost per discharge amount Ohio Administrative Code 5101:3-2-07.8, effective August 1, 2002). *More detail available in Administrative Code*
2.11	5	What is the payment policy when billed charges are less than DRG payment?	• The Ohio Administrative Code does not appear to mention this specifically, but does state that "a hospital may keep the difference between its prospective payment rate and costs incurred in furnishing inpatient services and is at risk for costs which exceed the prospective payment amounts." (Ohio Administrative Code 5101:3-2-07.11, effective date June 1, 2004). • Payments for DRG claims that include day outlier payments may not exceed allowable charges (Ohio Administrative Code 5101: 3-2-07.8, effective August 1, 2002). • Payments for DRG claims that include cost outlier payments may not exceed the lower of claim cost or allowable charges (Ohio Administrative Code 5101: 3-2-07.8, effective August 1, 2002).
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	Ohio uses the following outlier payments (Ohio Administrative Code 5101: 3-2-07.8, effective August 1, 2002): • Day outliers – used for extended lengths of stay based on the following thresholds: o DRGs 1 to 384, 391 to 468, 471 to 503: recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by two standard deviations. Payment is 60 percent of the per diem rate, which Ohio calculates by dividing the hospital's final prospective

ID	TASK	QUESTIONS	RESPONSES
			rate for the DRG (less capital and teaching allowance) by the statewide geometric mean length of stay calculated excluding outliers. Outlier payment equals the number of covered days beyond the day threshold multiplied by the per diem rate. The following hospitals will receive payment at 80 percent of the per diem rate: ▪ The hospital-specific outlier per cent is greater than one standard deviation over the statewide mean outlier per cent ▪ The hospital's ratio of medicaid, general assistance and Title V inpatient days to total inpatient days is greater than one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days o DRGs 388 to 290 and 892 to 898: recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by one standard deviation. Payment is 80 percent of the per diem rate (calculated per the above bullet) o DRGs 488, 489 or 190: Hospitals whose total number of cases used for setting relative weight that group into DRG 488, 489 or 490 is greater than two standard deviations above the statewide mean for all cases that fall into these DRGS receive 80 percent of the per diem rate (calculated per the above bullet) • Cost outliers – payment for high charge cases o DRGs 1 to 384, 391 to 468, 471 to 503: total allowed charges for an inpatient stay exceeds the statewide arithmetic mean charge – payment

ID	TASK	QUESTIONS	RESPONSES
			equals 60 percent of the difference between the statewide charge threshold and allowable charges. o The following hospitals will receive cost outlier payments equal to 85 percent of the product of allowed claim charges times the hospital-specific, Medicaid inpatient cost-to-charge ratio: ▪ The hospital-specific outlier per cent is greater than one standard deviation over the statewide mean outlier per cent ▪ The hospital's ratio of medicaid, general assistance and Title V inpatient days to total inpatient days is greater than one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days ▪ Hospitals whose total number of cases used for setting relative weight that group into DRG 488, 489 or 490 is greater than two standard deviations above the statewide mean for all cases • There are also payments for "exceptional outliers". *Note: Endnote 4 provides the Ohio Administrative Code for outlier payments.*
		How often is the high outlier payment policy updated?	Ohio inflates the outlier threshold amount for each DRG on January 1 of each year for inflation (Ohio Administrative Code 5101: 3-2-07.8, effective August 1, 2002)
2.14		Are conversion factors and the high outlier policy updated concurrently?	No

ID	TASK	QUESTIONS	RESPONSES
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	For teaching and children's hospitals, the conversion factor calculation includes the calculation of an outlier set-aside (or, "outlier adjustment amount"), which Ohio subtracts from the cost per discharge for each peer group.
2.16	6	What proportion of cases are paid using the outlier methodology?	Information not provided.
2.17	6	Are there interim outlier payment strategies? What are they?	Information not provided.
2.18	6	What methods are used to pay for transfer cases?	*Payment to Transferring Hospital* Per diem rate for each day of the patient's stay in the hospital, plus capital and teaching allowances, as applicable, not to exceed, for non-outlier cases, the final DRG rate that would have been paid, except for DRG 385 (neo-natal transfer) or 456 (burn cases that are transferred) (Ohio Administrative Code, 5101:3-2-07.11, effective date June 1, 2004). Ohio pays the full DRG payment to hospitals for DRGs 385 and 456. *Payment to Discharging Hospital* Per diem rate for each day of patient's stay in the discharging hospital, plus capital and teaching allowances, as applicable, not to exceed, for non-outlier cases, the final DRG rate for the DRG assigned by the transferring hospital (Ohio Administrative Code, 5101:3-2-07.11, effective date June 1, 2004) *Calculation of Per Diem Rate*

ID	TASK	QUESTIONS	RESPONSES
			Divide the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight by the statewide geometric mean length of stay calculated excluding outliers for the specific DRG into which the case falls (Ohio Administrative Code, 5101:3-2-07.11, effective date June 1, 2004).
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	Information not provided.
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	Information not provided.
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	Ohio calculates the conversion factor differently for different types of hospitals as follows (Ohio Administrative Code 5101:3-2-07, effective date August 21, 2003): • Children's hospitals --- 100 percent hospital-specific • Rural referral center hospitals – peer group average • Teaching hospitals – peer group average • Non-metropolitan statistical average area hospitals with less than 100 beds – peer group average • Non-metropolitan statistical average area hospitals 100 or more beds – peer group average • Metropolitan statistical average hospitals – peer group average – these hospitals are peer grouped on the basis of wage index categories

ID	TASK	QUESTIONS	RESPONSES
			• Out-of-state hospitals – Average cost per discharge that varies based on hospital type (teaching hospital, children's hospitals and all other). Ohio Administrative Code 5101:3-2-07.2 provides additional detail (effective data August 1, 2002).
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	No
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	Ohio pays for inpatient hospitals uses DRGs with the exception of the following providers/services which Ohio pays based on reasonable costs (Ohio Administrative Code, 5101:3-2-07.1, effective June 1, 2004): ▪ Freestanding rehabilitation hospitals excluded from Medicare PPS ▪ Freestanding long-term hospitals excluded from Medicare PPS ▪ Hospitals providing rehab and long-term care services that are excluded from Medicare PPS ▪ Ohio hospitals that are owned and operated by health insuring corporations licensed by the Ohio Department of Insurance and which limit services to Medicaid recipients ▪ Cancer hospitals

ID	TASK	QUESTIONS	RESPONSES
			▪ Selected transplant services – heart/lung and pancreas, liver/small bowel (Ohio Administrative Code, 5101:3-2-07.1, effective June 1, 2004)
3.2	3	For what services is the RCC methodology used?	▪ Freestanding rehabilitation hospitals excluded from Medicare PPS ▪ Freestanding long-term hospitals excluded from Medicare PPS ▪ Hospitals providing rehab and long-term care services that are excluded from Medicare PPS ▪ Ohio hospitals that are owned and operated by health insuring corporations licensed by the Ohio Department of Insurance and which limit services to Medicaid recipients ▪ Cancer hospitals ▪ Selected transplant services – heart/lung and pancreas, liver/small bowel (Ohio Administrative Code, 5101:3-2-07.1, effective June 1, 2004)
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	Medicaid inpatient costs, as reported on JFS 0293 (Ohio Medicaid Cost Report), Schedule H, Section I ÷ Medicaid inpatient charges, as reported on JFS 02930 (Ohio Medicaid Cost Report), Schedule H, Section I Ohio uses the ratio that is operational in the claims processing system on the date that the claim was paid for interim claim payments. These ratios reflect data from each hospital's cost report filed with Ohio during the calendar year proceeding the year during which the prospective rate year began.

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ID	TASK	QUESTIONS	RESPONSES
3.4	3	How often are RCCs recalculated or updated?	Annually
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	Information not provided.
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	Information not provided.
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	No
3.8	4	Describe the fixed payment per case methodology? How are payment levels determined?	No
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	No
3.10	4	What are the advantages or disadvantages of fixed payment per	Not applicable

ID	TASK	QUESTIONS	RESPONSES
		case methodologies over DRGs?	
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	Not applicable
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	Not applicable
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	Not applicable
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	Information not provided.
4.2		Of total inpatient payments, what percentage do CAH payments represent?	Information not provided.
4.3	3/9	What method does the state use to identify CAH hospitals?	Medicare's definition

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ID	TASK	QUESTIONS	RESPONSES
4.4	3/9	How does the state pay for inpatient CAH services?	DRG-based payments. CAHs receive an additional special DSH payment.
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	Ohio pays CAHs a special DSH payments.
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	Yes, Ohio uses a special CAH DSH payments
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	Information not provided.
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	CAHs are paid under DRGs,
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	Not applicable
4.10	3/9	Does the State perform cost settlements for CAHs?	Not applicable
4.11	3/9	Has the State observed any decreases or increases in the number of critical	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		access hospitals statewide? What are the reasons for changes in CAH status?	
4.12	3/9	How many CAHs are in the state currently?	Information not provided.
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	Not applicable
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	Not applicable
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	Not applicable
5.4	9	Does the State make special payments for Medicaid trauma care services?	Not applicable
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	Not applicable

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ID	TASK	QUESTIONS	RESPONSES
5.6	9	What is the specific methodology used to determine payment?	Not applicable
5.7	9	How often are these payments made?	Not applicable
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	Not applicable
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	Not applicable
5.10	9	What are these specific diagnosis or procedure codes?	Not applicable
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	Not applicable
5.12	9	How have the volume of trauma care services and Medicaid trauma care payments changed over time?	Not applicable
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma	Not applicable

ID	TASK	QUESTIONS	RESPONSES
		care services? What are they?	
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	Not applicable
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	Not applicable
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	None
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	Ohio does not distinguish payment based on border hospital status, but there are differences in conversion factor calculations between in-state and out-of-state hospitals (see conversion factor section above).
6.3		If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	Ohio does not distinguish payment based on border hospital status, but there are differences in conversion factor calculations between in-state and out-of-state hospitals (see conversion factor section above).
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	No
		Selective Contracting	

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ID	TASK	QUESTIONS	RESPONSES
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	Information not provided.
7.2		What percentage of hospitals are included in the State's selective contracting program?	Information not provided.
7.3	8	What services are subject to selective contracting?	Information not provided.
7.4	8	What are the selective contracting payment approaches to IP services?	Information not provided.
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	Information not provided.
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	Information not provided.
7.7	8	Is a facility-wide RCC used or departmental RCCs?	Information not provided.
7.8	8	What is the source of the RCCs?	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
7.9	8	How often are the RCCs used for payment updated?	Information not provided.
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	Information not provided.
8.2	8	Describe IP Centers of Excellence programs?	Information not provided.
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	Information not provided.
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	Information not provided.
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	Information not provided.
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	Services are paid based on DRG, but psychiatric hospitals receive an additional DSH payments
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	DRG
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	No
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	DRG
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		psychiatric unit?	
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	No.
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	No, although they do receive an additional DSH payments
10.2		If not, does the state provide higher payment rates to children's hospitals?	Yes, through additional DSH payments
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	Information not provided.
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	Information not provided.
		State Demographics	

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ID	TASK	QUESTIONS	RESPONSES
12.1		Ho many Medicaid recipients do you have?	Fiscal Year 2003 – 1,881,640 (Ohio Medicaid Report, January 2005)
12.2		What is your state's population?	Fiscal Year 2003 – 11,435,799 (Ohio Medicaid Report, January 2005)

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Oregon Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	• CMS/Medicare DRG: Inpatient • Interim RCC: Rural hospitals under 50 beds, CAHs • Final cost settlement: Rural hospitals under 50 beds, CAHs • Fixed payment per case: select children psych DPUs
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Information not provided: • AP-DRG or CMS/Medicare DRG _____ % • Percent of billed charges _____ % • Fixed payment per case _____ % • Fixed per diem _____ % • Other Method _____ %
1.3		How are the following services paid for?	<u>**Neonate Services**</u> • Neonate Services are reimbursed using DRG relative weights calculated from

ID	TASK	QUESTIONS	RESPONSES
			Oregon title XIX fee-for-service claims. See the discussion of relative weights below (ID 2.7). **Transplant Services** • Reimbursement for covered transplants and follow-up care for transplant services as follows (per 410-124-0000 OR Hospital Services Rulebook): – For transplants for fee-for-service or Primary Care Case Manager (PCCM) clients: ▪ Transplant facility services -- by contract with OMAP; ▪ Professional services -- at OMAP maximum allowable rates; – For emergency services, when no special agreement has been established, the rate is: ▪ 75% of standard inpatient billed charge; and ▪ 50% of standard outpatient billed charge; or ▪ The payment rate set by the Medical Assistance program of the state in which the center is located, whichever is lower. – For clients enrolled in FCHPs, reimbursement for transplant services is by agreement between the FCHP and the transplant center. **Rehab Services** • Rehab Services are reimbursed using DRG relative weights calculated from Oregon title XIX fee-for-service claims. See the discussion of relative weights below (ID 2.7). **Psych Services**

ID	TASK	QUESTIONS	RESPONSES
			• Adolescents – Adolescent Psych Services are reimbursed using DRG relative weights calculated from Oregon title XIX fee-for-service claims. See the discussion of relative weights below (ID 2.7). • Freestanding Psych Facilities – facility-specific contracts with the Mental Health Division. See discussion of psych payments below (ID 9.1). • Non-freestanding psych – reimbursed under DRG system. See discussion of psych payments below (ID 9.1) **HIV Services** • No discussion in OR Hospital Services Rulebook
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	**Low Volume DRG Relative Weights** (per 410-125-0141 OR Hospital Services Rulebook): • State-specific DRG relative weights (including Rehabilitation, Neonate, and Adolescent Psychiatric) lacking sufficient volume were developed by Myers and Stauffer based on the following: – Oregon non-Title XIX claims data; or – Data from other sources expected to reflect a population similar to the Oregon Title XIX caseload
1.5		What percentage of total payments do the following services represent?	Information not provided: Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ %

ID	TASK	QUESTIONS	RESPONSES
			AP-DRG low volume _____ %
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	**DSH** (per OR Hospital Services Rulebook 410-125-0150): • DSH Payment Calculations: – Medicaid Inpatient Days DSH Payment: The quarterly DSH payment is the sum of DRG weights for paid Title XIX non-Medicare claims for the quarter multiplied by a percentage (determined below) of the hospital conversion factor. The conversion factor used for eligible Type A and Type B hospitals (rural hospitals with less than 50 beds) and CAHs is set at the same rate as for out-of-state hospitals (see ID 2.6 below). The percentages are as follows: ▪ For eligible hospitals between one and two standard deviations above the mean, the disproportionate share percentage is 5%. ▪ For eligible hospitals between two and three standard deviations above the mean, the percentage is 10%. ▪ For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. – Low Income Utilization Rate DSH Payment: Eligibility under Criteria 2 -- The payment is the sum of DRG weights for claims paid by OMAP in the quarter, multiplied by the hospital's disproportionate share adjustment percentage and multiplied by the hospital's unit value. – Out-of-state Hospitals DSH Payment: The quarterly DSH payment is 5% of the out-of- state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals that have entered into agreements with

ID	TASK	QUESTIONS	RESPONSES
			OMAP for payment are reimbursed according to the terms of the agreement or contract. – Additional DSH Payments – Public Academic Medical Centers • Determination of Costs (DSH Payment Limit): – The most recent Medicare Cost Reports; or – OMAP's record of payments made during the same reporting period; or – Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period; or – Any information which OMAP, working in conjunction with representatives of Oregon hospitals, determines necessary to establish cost. **GME** • Direct Medical Education (per OR Hospital Services Rulebook 410-125-0141): – OMAP pays teaching hospitals for Direct Medical Education on a quarterly basis. – OMAP uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report). – Direct Medical Education cost per discharge is calculated as follows: ▪ The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX Direct Medical Education Cost per

ID	TASK	QUESTIONS	RESPONSES
			discharge. ▪ The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment. – Direct Medical Education Payment Per Discharge: ▪ The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter. ▪ The Direct Medical Education Payment per Discharge is adjusted by an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors. • <u>Indirect Medical Education (per OR Hospital Services Rulebook 410-125-0141):</u> – OMAP pays teaching hospitals for Indirect Medical Education on a quarterly basis. – Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. Oregon uses the indirect medical education factor in use by Medicare at the beginning of the State's fiscal year. – Indirect Medical Education quarterly payment: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital specific February 29, 2004 conversion factor, multiplied by the Indirect Factor. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

ID	TASK	QUESTIONS	RESPONSES
			• Graduate Medical Education Reimbursement for Public Teaching Hospitals ((per OR Hospital Services Rulebook 10-125-0142): – GME payment are made quarterly to in-state public acute care hospitals with a major teaching program, with 200 or more residents or interns. Oregon does not make GME payments to rural hospitals with less than 50 beds or to Critical Access Hospitals. GME payments are in addition to Direct Medical Education payments and Indirect Medical Education payments to compensate hospitals for GME costs incurred outside of the fee-for-service plan. – For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (becomes base year). – Total Direct Medical Education (DME) costs: the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME costs. – Indirect Medical Education (IME) costs: ▪ First OMAP determines the percentage of Medicare IME payments to total Medicare inpatient payments. This is calculated by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of the IME Adjustment and standard Medicare DRG payments (excluding outlier payments, inpatient program capital, and organ acquisition). ▪ The resulting percentage is then applied to net hospital allowable costs (total hospital allowable costs less Total DME costs).

ID	TASK	QUESTIONS	RESPONSES
			▪ Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days multiplied by to net hospital allowable costs. – GME payments: ▪ Total Title XIX GME costs are calculated by summing Title XIX IME and DME costs. Payments for Title XIX fee-for-service IME and DME are then subtracted from the Total Title XIX GME costs, resulting in net unreimbursed Title XIX GME costs for the base year. The net unreimbursed Title XIX GME costs for the base year are then multiplied by HCFA Prospective Payment System (PPS) Hospital Index. The additional GME payment is rebased yearly. ▪ Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population. • <u>Proportionate Share (Pro-Share) Payments for Public Academic Teaching Hospitals ((per OR Hospital Services Rulebook 410-125-0145):</u> – Proportionate Share (Pro-Share) payments are made to public academic teaching hospitals in the State of Oregon with 200 or more interns or residents. – Eligible academic hospitals are: ▪ State owned or operated hospital; or ▪ Non-state government owned or operated hospital. – The Pro-Share payment is specific to each classification and determined as follows: ▪ The federal upper payment limit determined in accordance with the specific requirements for each hospital classification for all eligible

ID	TASK	QUESTIONS	RESPONSES
			hospitals during the State Fiscal Year 2001; ▪ The Proportionate Share payment is calculated by the determination of Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments; ▪ The State of Oregon Medicaid Management Information System (MMIS) is the source of the charge and payment data. – Proportionate Share payments will be made quarterly during each federal fiscal year. Payments made during federal fiscal year will not exceed the Medicare upper limit calculated from January 1, 2001 through September 30, 2001 and quarterly for each federal fiscal year thereafter. – Per discussion with Department, OMAP is considering changing the payment methodology to incorporate length of stay.
1.7		Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	• Information not provided:
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	• Significant increase (per discussion with Department)
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	• Insignificant increase (per discussion with Department)
1.10	2	What has been the trend in Medicaid	• Significant increase (per discussion with Department)

ID	TASK	QUESTIONS	RESPONSES
		payments for inpatient services in the last 5 years?	
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	• No, relative weights are recalibrated annually (per discussion with Department)
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	• Information not provided:
1.13	2	What have been the payment/utilization/methods for RCC claims?	• Not used
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	• CMS Medicare IPPS (per OR Hospital Services Rulebook 410-125-0141): The Medicare Grouper is the software used to assign an individual claim to a DRG category. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. • CMS DRG Grouper Version 23 was scheduled to be effective 10/1/05, but the actual implementation is to be determined. Grouper logic has been modified

ID	TASK	QUESTIONS	RESPONSES
			to map Oregon-specific DRGs (per discussion with Department).
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	• DRG payments: calculated by adding the conversion factor to the capital amount, then multiplying by the DRG relative weight (per OR Hospital Services Rulebook 410-125-0141): – Conversion Factors: Oregon refers to its conversion factors as operating unit per discharge. Operating unit per discharge currently equals 100% of the operating unit payment as defined by Medicare 2004 data published in Federal Register/Vol. 68, No. 148, August 1, 2003. – Capital Amount: The capital payment is reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. OMAP uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report). The capital cost per discharge is currently 100% of the Medicare capital rate for fiscal year 2004 as published in Federal Register/Vol. 68, No. 148, August 1, 2003.
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	• Conversion factors are based on the Medicare System, which makes wage index adjustments for different labor markets.
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	• Conversion factors are based on the Medicare System, with no subsequent adjustments for GME, IME or DSH.

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	• Not applicable.
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	• Out-of-state hospitals receive the lesser of DRG reimbursement or billed charges. The conversion factor for contiguous out-of-state hospitals is set at the final unit value for the 50th percentile of Oregon hospitals. Please see the discussion of out-of-state hospitals below (ID 6.2).
2.7	3	What method was used to establish relative weights?	• **DRG Relative Weights** (per OR Hospital Services 410-125-0141): – OMAP establishes a relative weight based on federal Medicare DRG weights for most DRGs. – Rehabilitation, Neonate, and Adolescent Psychiatric DRGs were developed by Myers and Stauffer based on Oregon Title XIX fee-for-service claims. ▪ To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, OMAP uses the following methodology: Using the formula N = where Z = 1.15 (a 75% confidence level), S is the standard deviation, and R = 10% of the mean. OMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). ▪ State-specific DRG relative weights (including Rehabilitation, Neonate, and Adolescent Psychiatric) lacking sufficient volume were based on the following: o Oregon non-Title XIX claims data; or

ID	TASK	QUESTIONS	RESPONSES
			○ Data from other sources expected to reflect a population similar to the Oregon Title XIX caseload – When a test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the OMAP Title XIX population in that DRG, the weight derived from OMAP Title XIX claims history is used instead of the externally derived weight for that DRG.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	• When relative weights are recalculated, the overall Case Mix Index (CMI) is kept constant. Reweighing of DRGs or the addition or modification of the grouper logic is not to result in a reduction of overall payments or total relative weights (per OR Hospital Services 410-125-0141). Please see the discussion of relative weights above (ID 2.7).
2.9		How often is the AP-DRG relative weight recalibrated?	• Relative weights based on Federal Medicare DRG weights are established when changes are made to the CMS DRG Grouper. Oregon updates its DRG Grouper each year effective October 1st. • State specific relative weights are adjusted, as needed, as determined by OMAP (per OR Hospital Services 410-125-0141).
2.10		How often are conversion factors rebased, updated, or recalculated?	• OMAP does not have a regular rebasing schedule. The most recent conversion factor updates occurred on August 15, 2005 and March 1, 2004 (per discussion with Department).
2.11	5	What is the payment policy when billed charges are less than DRG payment?	• Payments will not exceed total of billed charges for fiscal year. Upper limits on payment of claims does not apply to Proportional Share (Pro-Share) eligible academic hospitals (per OR Provider Hospital Services 410-125-0155):

ID	TASK	QUESTIONS	RESPONSES
			• Payments are not limited to billed charges on a singe claim basis (per discussion with Department).
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	• Cost outlier cases are reimbursed as follows (per OR Hospital Services Rulebook 410-125-0141): – Non-covered services (such as ambulance charges) are deducted from billed charges; – The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload; – If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made; – Costs which exceed the threshold ($25,000 or 270% of the DRG payment, whichever is greater) are reimbursed using the following formula: ▪ Billed charges less non-covered charges, times; ▪ Hospital-specific cost-to-charge ratio equals; ▪ Net Costs, minus; ▪ 270% of the DRG or $25,000 (whichever is greater), equals; ▪ Outlier Costs, times; ▪ Cost Outlier Percentage, (cost outlier percentage is 50%), equals; ▪ Cost Outlier Payment.
2.13		How often is the high outlier payment policy updated?	• OMAP cost outlier policy is not subject to regular adjustments. OMAP last updated its outlier policy on 3/1/04 (per discussion with Department).

ID	TASK	QUESTIONS	RESPONSES
2.14		Are conversion factors and the high outlier policy updated concurrently?	• Updates to conversion factors and outlier policy are not related.
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	• Conversion factors are based on Medicare IPPS. Subsequent adjusted have not been made.
2.16	6	What proportion of cases are paid using the outlier methodology?	• Information not provided:
2.17	6	Are there interim outlier payment strategies? What are they?	• No. OMAP does not reimburse hospitals before the final discharge (per discussion with Department).
2.18	6	What methods are used to pay for transfer cases?	• Transfer Payments for transfers between DRG hospitals are calculated as follows (per 410-125-0165 OR Hospital Services Rulebook): – When a patient is transferred between hospitals, the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the Per Diem Inter-Hospital Transfer Payment rate. – The Per Diem Inter-Hospital Transfer Payment rate is equal to the DRG payment divided by the geometric mean length of stay for the DRG. Payment to the transferring hospital will not exceed the DRG payment. – The final discharging hospital receives the full DRG payment. • Transfers to distinct part rehab units (per OR Hospital Services Rulebook 410-125-0400): – The patient is considered discharged from an acute care facility when transferred to a distinct part rehab unit. The rehab unit then bills the

ID	TASK	QUESTIONS	RESPONSES
			admission as a separate claim.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	• Information not provided:
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	• Transfer payment methodology is applicable only to transfers between hospitals.
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	• Peer Groups are not used (per OR Hospital Services Rulebook).
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	• Not used.
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	• Type A and B hospitals (rural hospitals with less than 50 beds) are reimbursed based on an RCC on an interim basis. • Type A and B hospitals are retrospectively cost-settled during the annual cost settlement period for all covered inpatient services.

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ID	TASK	QUESTIONS	RESPONSES
3.2	3	For what services is the RCC methodology used?	• All services for type A and B hospitals except for Laboratory and Radiology services (OMAP fee schedule).
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	• The hospital specific cost to charge percentage is based on the last finalized cost settlement (per 410-125-0090 OR Hospital Services Rulebook).
3.4	3	How often are RCCs recalculated or updated?	• RCCs are updated annually as part of the fiscal year end settlement process (per discussion with Department).
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	• Information not provided.
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	• Information not provided.
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• Fixed payment per case: – Select children psych DPUs are paid on a per case basis (per discussion with Department).
3.8	4	Describe the fixed payment per case or per diem methodology. How are payment levels determined?	• Fixed payment per case: – Per case payments based on the length of stay (per discussion with Department).

ID	TASK	QUESTIONS	RESPONSES
			▪ Each days range (ex: 1-7 days) has its own per case payment rate. ▪ Rate is calculated based on the hospital unit value multiplied by a special Oregon specific weight for each day range. ▪ Total payment also includes payments for capital, DME, IME, DSH, and physician fees.
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	• No (per discussion with Department).
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	• Information not provided.
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	• Information not provided.
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	• Information not provided.
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	• Information not provided.

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ID	TASK	QUESTIONS	RESPONSES
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	• Information not provided.
4.2		Of total inpatient payments, what percentage do CAH payments represent?	• Information not provided.
4.3	3/9	What method does the state use to identify CAH hospitals?	• The Office of Rural Health designates Critical Access Oregon Hospitals (per 410-125-0090).
4.4	3/9	How does the state pay for inpatient CAH services?	• Critical Access Hospitals Reimbursement (per 410-125-0090 of the Oregon Hospital Services Rulebook): – Interim reimbursement for inpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except Laboratory and Radiology services are based on the Office of Medical Assistance Programs (OMAP) fee schedule. – Retrospective cost-based reimbursement is made during the annual cost settlement period for all covered inpatient services, except for the hospitals that have payment contracts with managed care plans. – Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services. – Critical Access Hospitals are eligible for disproportionate share reimbursements, but must meet the same criteria as other hospitals.

ID	TASK	QUESTIONS	RESPONSES
			– Critical Access Hospitals do not receive cost outlier, capital, or medical education payments.
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	• Yes (see ID 4.4 above) – Interim payments: cost-to-charge ratio method – Final payments: cost-settled using cost based method
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	• Not Applicable
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	• Information not provided.
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	• Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services (per 410-125-0090 OR Hospital Services Rulebook).s
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	• Interim reimbursement for inpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except Laboratory and Radiology services are based on the Office of Medical Assistance Programs (OMAP) fee schedule (per 410-125-0090 OR Hospital Services Rulebook)
4.10	3/9	Does the State perform cost settlements	• Yes. See ID 4.4 above

ID	TASK	QUESTIONS	RESPONSES
		for CAHs?	
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	• Information not provided.
4.12	3/9	How many CAHs are in the state currently?	• Information not provided.
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	• Not Applicable
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	• Not Applicable
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	• Not Applicable
5.4	9	Does the State make special payments for Medicaid trauma care services?	• Not Applicable

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ID	TASK	QUESTIONS	RESPONSES
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	• Not Applicable
5.6	9	What is the specific methodology used to determine payment?	• Not Applicable
5.7	9	How often are these payments made?	• Not Applicable
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	• Not Applicable
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	• Not Applicable
5.10	9	What are these specific diagnosis or procedure codes?	• Not Applicable
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	• Not Applicable
5.12	9	How have the volume of trauma care services and Medicaid trauma care	• Not Applicable

ID	TASK	QUESTIONS	RESPONSES
		payments changed over time?	
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	• Not Applicable
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	• Not Applicable
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	• Not Applicable
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	Border Hospital Definition (Per 410-125-0121 OR Hospital Services Rulebook): • Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border.
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	• **Contiguous** area out-of-state hospitals payment methodology (per OR Hospital Services Rulebook 410-125-0121): – Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals receive the lesser of DRG reimbursement or billed charges. The unit value for contiguous out-of-state hospitals is set at the final unit value for the 50th percentile of Oregon hospitals. Contiguous area out-of-state hospitals are also eligible for cost outlier

ID	TASK	QUESTIONS	RESPONSES
			payments. No capital or medical education payments will be made. The capital amount will be set at zero. The hospital will receive a disproportionate share reimbursement if eligible. • **Non-contiguous** area out-of-state hospitals payment methodology (per 410-125-0115 of the Oregon hospital rulebook): – Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, non-contiguous area out-of-state hospitals will be reimbursed under the same methodology as contiguous area hospitals with the exception that non-contiguous hospitals are not eligible to receive cost outlier payments.
6.3		If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	• Not applicable
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	• RCC method not used.
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	• OMAP uses Center of Excellence Program for certain services (see ID 8.1).
7.2		What percentage of hospitals are	• Centers of Excellence are out-of-state.

ID	TASK	QUESTIONS	RESPONSES
		included in the State's selective contracting program?	
7.3	8	What services are subject to selective contracting?	• See ID 8.1
7.4	8	What are the selective contracting payment approaches to IP services?	• See ID 8.1
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	• See ID 8.1
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	• See ID 8.1
7.7	8	Is a facility-wide RCC used or departmental RCCs?	• See ID 8.1
7.8	8	What is the source of the RCCs?	• See ID 8.1
7.9	8	How often are the RCCs used for payment updated?	• See ID 8.1
	8	**Centers of Excellence**	

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ID	TASK	QUESTIONS	RESPONSES
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	• OMAP uses Centers of Excellence Program for the following services (per discussion with Department): – Transplants (liver, heart/lung combo) – Children's cancers – Other rare cancers
8.2	8	Describe IP Centers of Excellence programs?	• OMAP contracts with Centers of Excellence out-of-state for services not available in Oregon (per discussion with Department).
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	• Information not provided:
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	• Information not provided:
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	• OMAP reimburses Centers of Excellence based on a percent of billed charges (per discussion with Department).
8.6	8	Does the global package rate for transplants include professional	• Rates include the cost of transportation (per discussion with Department).

ID	TASK	QUESTIONS	RESPONSES
		services and any pre- or post-transplant services?	
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	• Free-standing IP Psych facilities are reimbursed according to hospital-specific agreements with the Mental Health Division (per OR Hospital Services Rulebook 410-125-0125). • All other IP Psych services are reimbursed according to the same DRG methodology as acute medical services (per OR Hospital Services Rulebook 410-125-0141).
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	• DRG method and specific contract arrangements (Please see ID 9.1 above)
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	• Information not provided.
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	• Psychiatric services are paid with the DRG methodology unless services are provided at a freestanding psych hospital (please see ID 9.1 above).
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital	• DRG Method (please see ID 9.1 above)

ID	TASK	QUESTIONS	RESPONSES
		that does not have a distinct part psychiatric unit?	
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	• No – paid under DRGs
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	• There is 1 children's hospital in Oregon, and it is billed through OHSU under the DRG methodology (per discussion with Department).
10.2		If not, does the state provide higher payment rates to children's hospitals?	• No (per discussion with Department).
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	• Managed Care Enrollment: – Certain Medicaid recipients are required to enroll in a Managed Care Plan as identified by specified zip codes in presumably urban areas (per OR DHS website). • 4 Types of Managed Care Contracts (per Oregon DHS Website): – Fully Capitated Health Plans – Dental Care Organizations – Chemical Dependency Organizations

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ID	TASK	QUESTIONS	RESPONSES
			– Physician Care Organizations
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	• Directly Negotiated Payment Rates: Contracts specify services and payments rates. Hospitals are then responsible for notifying OMAP of the negotiated services and rates within 30 days of OMAP's request. (Per OR Hospital Services Rulebook 410-125-1070)
		State Demographics	
12.1		Ho many Medicaid recipients do you have?	• FFY 2002 total Medicaid beneficiaries: 621,462 (per original OR matrix)
12.2		What is your state's population?	• 3,559,596 in 2003 (per US Census Bureau)

Washington State Medicaid
Inpatient Hospital Rebasing Project
Pennsylvania Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	• CMS/Medicare DRG: Acute care services. Please see the discussion of conversion factors below (ID 2.2) • Fixed per diem: Psychiatric, medical rehabilitation, and detox services. Please see the discussion of fixed per diems below (ID 3.7).
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	• The following percentages represent a portion of total inpatient *fee-for-service* payments based on a FYE 2003 NCI cost coverage analysis. Analysis includes two out-of-state hospitals. Managed care payments are not included. – CMS/Medicare DRG: 76.9% (includes outliers and transfers) – Fixed per diem: 23.1% – Percent of billed charges: 0% – Fixed payment per case: 0% – Other Method: 0%
1.3		How are the following services paid	**Neonate Services** – paid under the DRG method for acute services. Abnormal

ID	TASK	QUESTIONS	RESPONSES
		for?	newborns may qualify for high cost outlier payments. Please see the discussion of outliers below (ID 2.12). **Transplant Services** – Transplants are not exempt from the DRG prospective payment system in 55 PAC 1163. Transplants are assigned DRGs and relative weights in the fee-for-service system. **Rehab Services** – paid under the fixed per diem method. Please see the discussion of per diems below (ID 3.8). **Psych Services** – paid under the fixed per diem method. Please see the discussion of per diems below (ID 3.8). **HIV Services** – HIV services are not exempt from the DRG prospective payment system in 55 PAC 1163. HIV services are assigned DRGs and relative weights in the fee-for-service system.
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	• Relative weights for DRGs without sufficient paid claims data (approximately less than 20) are taken from the Medicare IPPS.
1.5		What percentage of total payments do the following services represent?	• The following percentages represent a portion of total inpatient *fee-for-service* payments based on a FYE 2003 NCI cost coverage analysis. Analysis includes two out-of-state hospitals. Managed care payments are not included. – Rehab Services: 5.3% – Psych Services: 17.8% – Neonate Services: not calculated in NCI analysis – Transplant Services: not calculated in NCI analysis

ID	TASK	QUESTIONS	RESPONSES
			– AP-DRG low volume: not calculated in NCI analysis
1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	**DSH payments** (per 55 PAC 1163.67): • Inpatient DSH Payments – The Department provides Inpatient DSH funding for in-state hospital providers that serve a disproportionate share of MA recipients. Acute care general hospitals, psychiatric, medical rehabilitation, and drug and alcohol rehabilitation units of acute care general hospitals, freestanding rehabilitation hospitals, and private psychiatric hospitals are eligible for Inpatient DSH payments. – The Department prospectively calculates the annual Inpatient DSH payments by multiplying the disproportionate share percentage by the hospital's projected Title XIX and GA income for acute care cases during the fiscal year. Annual payments are divided into four quarterly installments. The Inpatient DSH payment pool has historically been updated through agreements between the hospital industry and the Department. • Additional DSH Payments – The Department makes two additional payments referred to as "Community Access Funds": ▪ Payment for certain hospitals that rendered a high volume of uncompensated care or charity care and which had experienced a significant reduction in revenue as a result of changes to the MA program eligibility regulations. ▪ Payment for certain hospitals which rendered charity care in excess of the average inpatient charity care cost.

ID	TASK	QUESTIONS	RESPONSES
			– Uncompensated Care and Extraordinary Expense: payments for hospitals that incur significant uncompensated care costs, or experience a high volume of inpatient cases, the cost of which exceeds twice the hospital's average cost per stay for all patients. – Temple University Hospital DSH payment – High volume DSH payment - hospitals with at least 60% MA days, provided a broad spectrum of inpatient services, and had liabilities which exceeded its assets. – Trauma Payment - DSH payment to accredited trauma centers in the Commonwealth. – Volume Method DSH Payments – Mercy Hospital Payment **Direct medical education** • Initially, direct medical education was reimbursed via monthly interim payments and cost settled (per 55 PAC 1163.55): (a) For Fiscal Years 1993-94 and 1994-95, the Department will reimburse hospitals for inpatient acute care direct medical education costs that are allowable under Medicare cost principles, subject to the limitations in this section. (b) For Fiscal Years 1993-94 and 1994-95, prior to a settlement based on audited costs, subject to the limitations in this section, the Department will make monthly interim payments for the MA inpatient acute care portion of a hospital's allowable costs for direct medical education. The Department will calculate a hospital's interim payment to approximate, to the extent practicable, that hospital's final audited MA inpatient acute care

ID	TASK	QUESTIONS	RESPONSES
			direct medical education payment. (c) For Fiscal Years 1993-94 and 1994-95, a hospital's final audited payment for MA inpatient acute care direct medical education costs will be the lesser of the following: (1) The hospital's final audited MA inpatient acute care direct medical education payment for the prior fiscal year, as increased for inflation to the fiscal year being audited. (2) The hospital's actual audited MA inpatient acute care direct medical education costs for the fiscal year being audited. (d) For Fiscal Year 1993-94, the inflation factor is 3%. (e) For Fiscal Year 1994-95, the inflation factor is the Consumer Price Index—Wage Earners Percent Change (% CHYA) Index as published by DRI/McGraw-Hill in the fourth calendar quarter of 1993 for the second calendar quarter of 1995. • Currently, direct medical education is paid quarterly and is not cost settled (per hospital rate agreement). Update factors are negotiated annually.
1.7		Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	• Per FYE 2002 Form CMS 64 (includes both "regular" inpatient and Mental Health Facility Services. CMS 64 does not list GME separately): – DSH payments: $779,176,586 – Inpatient fee-for-service payments: $602,691,737 – DSH plus inpatient fee-for-service payments: $1,381,868,323 – DSH percentage of DSH plus inpatient fee-for-service payments: 56.4%
1.8	2	What has been the trend in inpatient	• Department does not track

ID	TASK	QUESTIONS	RESPONSES
		acute care hospital billed charges in the last 5 years?	
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	• Utilization has generally increased (per discussion with Department). • Pennsylvania is generally moving towards managed care (currently 65-70% managed care).
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	• Aggregate expenditures have generally increased (per discussion with Department).
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	• Department does not track.
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	• The following represents a portion of total inpatient *fee-for-service* payments based on a FYE 2003 NCI cost coverage analysis. Analysis includes two out-of-state hospitals. Managed care payments are not included. – $67,765,122 out of $601,384,419 (11.3%) in total inpatient fee-for-service payments.
1.13	2	What have been the payment/utilization/methods for RCC claims?	• Not applicable.
		DRG-Related Issues	

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ID	TASK	QUESTIONS	RESPONSES
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	• The Department is using CMS DRG Grouper version 22 as of September 2005. • The Department is considered switching to the APR-DRG Grouper for acute services.
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	• Computation of the hospital-specific base payment rates is based on the case mix adjusted hospital cost per discharge from FYE 1987 (per 55 PAC 1163.126). Conversion Factors are updated for inflation on an annual basis. – Identify the hospital's Reported MA Allowable Costs from the hospital's base year Fiscal Year 1986-87 Cost Report (MA 336) and subtract from this amount each of the following items: (1) The MA portion of the hospital's inpatient costs for direct medical education. (2) The MA portion of the hospital's allowable net inpatient costs for depreciation and interest for buildings and fixtures. – Adjust to account for differences between the hospital's reported MA days for the base year and the MA days contained in the Department's claims database for the base year. The adjustment formula is as follows: Adjusted net MA allowable cost = (MA claims days / hospital's reported MA days) x hospital's adjusted inpatient acute care MA costs – Hospital's Net Cost equals Adjusted Net MA Allowable Costs minus each of the following:

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
			(1) The cost outlier portion of costs for claims that qualify as cost outliers. (2) Day outlier portion of costs for claims that qualify as day outliers. (3) The costs of transfer claims except for DRGs 385 and 456. (4) The costs of the hospital's claims which are no longer paid as inpatient claims. (5) The cost of psychiatric claims exclusive of the first 2 days of the hospital stay, for hospitals without a distinct part psychiatric unit enrolled in the MA Program. (6) The full costs of psychiatric claims, for hospitals with a distinct part psychiatric unit enrolled in the MA Program. (7) The costs of drug and alcohol claims exclusive of the first 2 days of the hospital stay, for hospitals that are not approved for drug and alcohol detoxification services. (8) The full costs of drug and alcohol claims, for hospitals with a distinct part drug and alcohol unit enrolled in the MA Program. – Reduce the hospital's net cost by an over-reporting factor of 1.77%. – Divide the Reduced Hospital Net Cost by the adjusted number of MA cases for that year to calculate the Hospital's average cost per case. The adjusted MA cases calculation is as follows: (1) Identify the hospital's total number of MA claims in the base year using the Department's paid claims database for the base fiscal year. (2) Subtract each of the following items: (i) The number of claims identified for psychiatric services for hospitals with distinct part psychiatric units enrolled in the MA Program. (ii) The number of claims identified for drug and alcohol treatment

ID	TASK	QUESTIONS	RESPONSES
			services for hospitals with distinct part drug and alcohol units enrolled in the MA Program. (iii) The number of claims involving patient transfers, except for transfers occurring in DRGs 385 and 456. (iv) The number of claims identified involving MA cases which were eligible for Medicare reimbursement. (v) The number of claims which are no longer paid as inpatient claims. – Divide the hospital's average cost per case by the hospital-specific case mix index to calculate the Base Year Case Mix Adjusted Cost per Case. The hospital-specific case mix index calculation is as follows: (1) Identifying the total number of MA DRG cases for the hospital for the base year from the Department's paid claims data. (2) Summing the relative values of each case to calculate an aggregate relative value amount for the hospital. (3) Divide the hospital's aggregate relative value amount by the number of MA cases to establish a hospital-specific case mix index.
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	• No – rates are based on facility-specific costs.
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	• The costs for direct medical education are removed from the determination of conversion factors. Please see the discussion of conversion factors above (ID 2.2).

ID	TASK	QUESTIONS	RESPONSES
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	• Not applicable.
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	• 55 PAC 1163 does not distinguish between border and non-border out-of-state hospitals. Out-of-state hospitals are generally reimbursed under the DRG system using a statewide average conversion factor. Out-of-state hospitals with more than 400 PA MA cases receive hospital-specific conversion factors. Please see the discussion of out-of-state rates below (ID 6.2).
2.7	3	What method was used to establish relative weights?	• Relative weights (called "relative values") are Pennsylvania specific (per 55 PAC 1162.122): – The relative values are based on the following: ▪ Using the Department's most recent paid claims data available for at least a 2-year period, establish a data base of claims appropriate for payment under the DRG payment system by removing claims: (i) For distinct part psychiatric units excluded from the DRG payment system. (ii) For distinct part drug and alcohol treatment units excluded from the DRG payment system. (iii) For services previously paid as inpatient hospital services but which are no longer paid as inpatient claims. (iv) For those that group into DRGs 469 and 470. (v) For those indicating that Medicare made part of the payment. (vi) For those involving patient transfers, except for transfers occurring in

ID	TASK	QUESTIONS	RESPONSES
			DRGs 385 and 456. (vii) For distinct part medical rehabilitation units excluded from the DRG payment system. ▪ The hospital's most recent cost report on file with the Department. – Determine each hospital's general care per diem cost, special care units (eg., ICU, CCU, etc.) per diem costs and cost to charge ratios for each of the hospital's ancillary departments. For hospitals with excluded units, the general care per diem cost for the prospectively paid portion of the hospital will be used when available. – The cost of each claim in the Department's paid claims file is calculated as follows: ▪ For claims from the same year as the hospital's most recent cost report on file with the Department, the cost of each claim is determined as follows: (i) Multiply the claim's general care unit days by the hospital's general care unit per diem. (ii) Multiply the claim's special care unit days, if any, by the unit's corresponding special care unit per diem. (iii) Multiply the ancillary charges indicated on the invoice by a cost to charge ratio that corresponds to the ancillary department. If detailed ancillary charges are not available, the overall cost to charge ratio of the hospital is used to convert changes to costs. (iv) Sum the amounts from (i)—(iii) to establish the costs of the claim. (v) Remove, when necessary, the portion of the costs on the claims attributable to:

ID	TASK	QUESTIONS	RESPONSES
			(A) Depreciation and interest. (B) Direct medical education. (C) Direct care physicians' services. ▪Claims from the years preceding the year of the hospital's last filed cost report are inflated to the year of the hospital's last filed cost report. ▪Claims from years following the year of the hospital's last filed cost report are deflated to the year of the hospital's last filed cost report. – The Department adjusts the cost of a claim by: ▪ Computing a hospital specific average cost per case by dividing the total costs for claims in a hospital by the total number of claims for the hospital. ▪ Computing a Statewide average cost per case by dividing the total costs for all claims by the total number of claims. ▪ Dividing the cost per case by the Statewide average cost per case to determine a hospital specific standardization factor. ▪ Multiplying the cost of a hospital's claim by its corresponding standardization factor. – The Department computes the relative value for each DRG by: ▪ Determining the total standardized cost for all approved claims in the database. ▪ Determining the total number of MA hospital cases in the database. ▪ Dividing the total standardized costs by the total number of cases to establish a Statewide average cost per case for all cases. ▪ Determining the total costs and total number of cases for each DRG. ▪ Dividing the total costs for each DRG by the corresponding number of MA

ID	TASK	QUESTIONS	RESPONSES
			cases for that DRG to establish an average cost per case for each DRG. ▪ Dividing the average cost per case for each DRG by the Statewide average cost per case for all cases to establish the relative value for each DRG.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	• Please see the discussion of the calculation of relative weights above (ID 2.7). • Relative weights for new DRGs that arise from the latest DRG Grouper are calculated based on Medicaid claims data.
2.9		How often is the AP-DRG relative weight recalibrated?	• DRGs 493 and higher are recalibrated on an annual basis based on Medicaid claims data. DRGs lower then 493 have not been recalibrated in several years.
2.10		How often are conversion factors rebased, updated, or recalculated?	• 55 PAC 1163 does not discuss a schedule for rebasing conversion factors. Conversion factors have not been rebased since the release of the 86/87 MA Cost Report. • Conversion factors are updated for inflation on an annual basis.
2.11	5	What is the payment policy when billed charges are less than DRG payment?	• Payments are capped at charges (per 55 PAC 1163.453): The Department may not make payment for a service at a rate higher than the hospital's customary charge. The hospital's customary charge is the usual charge to the general public for a specific service.
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	• **Cost Outliers** (per 55 PAC 1163.56): – The Department will pay an amount in addition to the DRG payment if the hospital stay groups into DRG 385-390, 456-460 or 472, or is a major burn claim or abnormal newborn claim which would have grouped into one of those DRGs under grouper version 7. – A qualified DRG receives a cost outlier payment if the cost of the case

ID	TASK	QUESTIONS	RESPONSES
			exceeds 150% of the hospital's DRG base payment. The Department will calculate the cost of the case by multiplying the charges indicated on the invoice by the hospital's cost-to-charge ratio. – To receive payment for a case identified as a cost outlier, the following conditions shall be met: (1) The hospital shall submit a copy of the patient's medical record with the invoice submitted for payment. (2) The Department will certify the medical necessity of the days of care and the services provided. (3) The hospital stay shall qualify as a cost outlier based on the medically necessary days and services certified by the Department. – The outlier payment amount for a cost outlier is 100% of the cost of the case that exceeds 150% of the hospital's base payment amount for the DRG. • **Day Outliers** (per 55 PAC 1163.56): – Except for cost outliers, to qualify as a day outlier the inpatient hospital stay of an MA recipient must exceed the trim point for the DRG. The trim point for a DRG is the lesser of one of the following: (1) Twenty days above the geometric mean length of stay for the DRG. (2) 1.94 standard deviations above the geometric mean length of stay for the DRG. – To receive payment for a case identified as a day outlier, the following conditions must be met: (1) The hospital shall submit a copy of the patient's medical record with the

ID	TASK	QUESTIONS	RESPONSES
			invoice submitted for payment. (2) The Department will certify the medical necessity of all days of care provided. (3) The hospital stay shall qualify as a day outlier based on the medically necessary days certified by the Department. – The Department determines the outlier payment amount for a day outlier by: (1) Determining a per diem amount for the DRG by dividing the hospital's payment amount for the DRG by the Statewide average length of stay for the DRG. (2) Multiplying the per diem amount for the DRG by 60% to establish the marginal per diem rate for the DRG. (3) Subtracting the number of days at the trim point for the outlier from the actual number of inpatient hospital days to establish the number of outlier days. (4) Multiplying the marginal per diem rate by the number of outlier days to establish the outlier payment amount.
2.13		How often is the high outlier payment policy updated?	• 55 PAC 1163 does not discuss a schedule for updating the outlier payment policy. The outlier method is based on a percentage of the DRG payment, and will not be updated on a regular basis.
2.14		Are conversion factors and the high outlier policy updated concurrently?	• Updates of conversion factors and outliers are not related.
2.15	6	How are expected outlier payments	• The cost of day and cost outlier claims are removed from the determination of

ID	TASK	QUESTIONS	RESPONSES
		considered or factored into the determination of conversion factors?	hospital conversion factors. Please see the discussion of the conversion factors above (ID 2.2)
2.16	6	What proportion of cases are paid using the outlier methodology?	• The following represents the portion of outlier claims to total inpatient *fee-for-service* claims based on a FYE 2003 NCI cost coverage analysis. Analysis includes two out-of-state hospitals. Managed care is not included. – 1,843 out of 111,483 (1.7%) in total inpatient fee-for-service claims.
2.17	6	Are there interim outlier payment strategies? What are they?	• Hospital stays longer than 90 days are eligible for an interim payment, regardless of whether the stay qualifies for an outlier payment (per 55 PAC 1163.51(i)).
2.18	6	What methods are used to pay for transfer cases?	• Transfer cases are paid as follows (per 55 PAC 1163.58): – A transfer is limited to those instances in which a patient is transferred between two hospitals both of which are paid under the MA prospective payment system. – Except as specified below, if an inpatient is transferred, the hospital that discharges the inpatient is paid the full DRG rate established under this chapter. – Except as specified below, if an inpatient is transferred, the transferring hospital is paid the lesser of one of the following: (1) A per diem rate for each day of inpatient care determined by dividing the hospital's appropriate DRG payment rate for the case by the Statewide average length of stay for the DRG. (2)The hospital's appropriate DRG payment rate as determined under this chapter.

ID	TASK	QUESTIONS	RESPONSES
			– In computing the per diem payment, the day of transfer is a non-compensatable day unless it is also the day of admission. – If the case being transferred is classified into DRG 385 or DRG 456, the transferring hospital is paid the full DRG rate. – A hospital transferring a patient is paid the full DRG rate established under this chapter only if: (1) The patient was admitted to the hospital by way of a transfer from the acute care setting of another hospital paid under the DRG payment system. (2) The patient is classified into one of the DRGs from 386 through 390 or 457 through 460 inclusive. – If a patient has been transferred to a hospital under, the discharging hospital is paid the lesser of one of the following: (1) The DRG payment rate for the case. (2) An amount determined by: (i) Dividing the hospital's DRG payment rate by the Statewide average length of stay for the DRG. (ii) Multiplying the amount by the number of days in the hospital. (iii) Multiplying the amount by .60 to establish a marginal per diem payment amount for the hospital.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	• The following represents the percent of inpatient acute fee-for-service transfer claims and payments based on a FYE 2003 NCI cost coverage analysis. Analysis includes two out-of-state providers. Psych and rehab fee-for-service

ID	TASK	QUESTIONS	RESPONSES
			as well as managed care were not included. – Transfers accounted for 2,244 out of 84,260 (2.7%) total fee-for-service acute claims. – Transfers accounted for $6,042,770 out of $462,608,150 (1.3%) total fee-for-service acute payments.
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	• The Department excludes non-inpatient hospitals from the standard transfer payment methodology.
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	• No. Please see the discussion of conversion factors above (ID 2.2).
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	• No. Please see the discussion of conversion factors above (ID 2.2).
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	• Not Applicable – RCC methodology not used.
3.2	3	For what services is the RCC methodology used?	• Not Applicable – RCC methodology not used.

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ID	TASK	QUESTIONS	RESPONSES
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	• Not Applicable – RCC methodology not used.
3.4	3	How often are RCCs recalculated or updated?	• Not Applicable – RCC methodology not used.
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	• A day of inpatient hospital care is defined as follows (per 55 PAC 1163.2): – Room, board and professional services furnished to a patient on a continuous 24-hour-a-day basis in a semi-private room of a hospital. • Pennsylvania follows Medicare allowable cost rules except where otherwise noted.
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	• Per Medicare allowable cost rules, the additional cost from private room stays are removed during the calculation of the adult and pediatric cost per diem.
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• Freestanding medical rehabilitation hospitals and units and drug and alcohol rehabilitation hospitals and units receive per diem payments based on costs (per 55 PAC 1163.452). • Freestanding psychiatric hospitals and units receive per diem payments based on costs (per 55 PAC 1151.46).
3.8	4	Describe the fixed payment per case or per diem methodology. How are payment levels determined?	**Per Diem Payments** • Medical Rehab and Detox services (per 55 PAC 1163.451-452): – Initially, rehab and drug and alcohol services were paid an interim per diem

ID	TASK	QUESTIONS	RESPONSES
			and cost-settled after the hospital cost report was audited by the Auditor General. – Freestanding rehabilitation hospitals: interim rates were calculated by determining the MA cost per diem without ceiling adjustments from the FYE 1988 MA cost report. The cost per diem is then inflated to the rate year based on the DRI hospital market basket inflation index. – Rehabilitation units: interim rates were calculated by determining the MA cost per diems without ceiling adjustments over several fiscal years from the MA cost report. The cost per diems are then inflated to the rate year based on the DRI hospital market basket inflation index. The lowest cost per diem becomes the interim rate. – Drug and alcohol units: interim rates were calculated by determining the MA cost per diems without ceiling adjustments over several fiscal years from the MA cost report. The cost per diems are then inflated to the rate year based on the DRI hospital market basket inflation index. The lowest cost per diem becomes the interim rate. – Interim payment per diems were subject to the per diem rate caps. The cap was not applied to services for children under one year of age. For Fiscal Year 1994-95, the cap was $950 adjusted for inflation effective January 1, 1995 by the inflation factor determined by the Department inclusive of cost which may be excluded from the upper limits on payment, but exclusive of disproportionate share payments. – Interim rates and cost settling for existing hospitals were discontinued in January 2002. Currently rehab services are reimbursed via a prospective per diem rate without cost settling. Per diem rates are updated for inflation on an annual basis. Rate updates are specified in the provider rate agreements

ID	TASK	QUESTIONS	RESPONSES
			(per discussion with Department). • Psychiatric services (per 55 PAC 1151.46): – Psych facilities receive a per diem rate, and are not cost-settled. Final Payments are subject to a per diem cap. The per diem payment rate for an existing provider is the facility's MA per diem cost as reported on the Fiscal Year 1989-90 MA Cost Report reduced by the over reporting factor of 1.69% and inflated by an inflation factors determined by the Department. – Payments are subject to interim and final per diem caps. (1) The interim per diem payment rate is the MA per diem cost from the earliest available cost report, or on an approved projected budget, reduced by the over-reporting factor of 1.69%, and inflated by an inflation factor determined by the Department. (2)The final per diem payment rate is the audited MA per diem cost of the facility's first full fiscal year of operation in the MA Program, inflated by the appropriate inflation factors. • New Psych and Rehab Hospitals: – Currently new hospitals paid under a per diem methodology are cost-settled until a per diem rate can be determined from a submitted PA MA Cost Report. New hospitals receive an interim rate based on a budgeted PA MA Cost Report (per discussion with Department).
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are	• No.

ID	TASK	QUESTIONS	RESPONSES
		outlier payment amounts determined?	
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	• Not applicable
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	• Not applicable
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	• Not applicable
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	• Not applicable
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	• Currently there are 5 Critical Access Hospitals recognized by Medicare (per PA Rural Health Website).
4.2		Of total inpatient payments, what percentage do CAH payments represent?	• CAHs are not paid under a separate methodology. Please see ID 4.4

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ID	TASK	QUESTIONS	RESPONSES
4.3	3/9	What method does the state use to identify CAH hospitals?	• Department does not recognize Critical Access Hospitals (per discussion with Department).
4.4	3/9	How does the state pay for inpatient CAH services?	• CAHs are not paid under a separate methodology, nor do they receive special CAH add-on payments (per discussion with Department). CAHs are paid under the appropriate prospective payment method as other inpatient hospitals. CAHs are eligible for DSH payments.
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	• Not applicable
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	• No. Please see ID 4.4
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	• Department does not recognize Critical Access Hospitals (per discussion with Department).
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	• Not applicable
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	• Not applicable

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ID	TASK	QUESTIONS	RESPONSES
4.10	3/9	Does the State perform cost settlements for CAHs?	• No. Please see ID 4.4
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	• Department does not recognize Critical Access Hospitals (per discussion with Department).
4.12	3/9	How many CAHs are in the state currently?	• Please see ID 4.1
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	• Not applicable
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	• Not applicable
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	• Not applicable
5.4	9	Does the State make special payments	• Trauma DSH payments (annual lump sum payments).

ID	TASK	QUESTIONS	RESPONSES
		for Medicaid trauma care services?	
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	• Not applicable
5.6	9	What is the specific methodology used to determine payment?	• Not applicable
5.7	9	How often are these payments made?	• Not applicable
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	• Not applicable
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	• Not applicable
5.10	9	What are these specific diagnosis or procedure codes?	• Not applicable
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	• Not applicable
5.12	9	How have the volume of trauma care	• Not applicable

ID	TASK	QUESTIONS	RESPONSES
		services and Medicaid trauma care payments changed over time?	
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	• Not applicable
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	• Not applicable
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	• Not applicable
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	• 55 PAC 1163 does not distinguish between border and non-border out-of-state hospitals.
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	• Most out-of-state hospitals are reimbursed under the DRG system based on a statewide average conversion factor (per 55 PAC 1163.65): – The Department's payment for services provided by an out-of-State hospital is the lower of: (1) The amount of the charges billed by the hospital. (2) The Statewide average DRG payment rate, excluding capital, increased by 7.1% to account for capital-related costs for buildings and fixtures and, if applicable, an outlier payment.

ID	TASK	QUESTIONS	RESPONSES
			– The Department subtracts from the hospital payment any payments from the recipient, a legally responsible relative or a third-party resource. • Hospitals with more than 400 PA MA cases qualify for a hospital-specific conversion factor (per State Plan Attachment 4.19(A) page 11). Currently, two out-of-state hospitals receive hospital-specific conversion factors.
6.3		If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	• Please see the discussion of out-of-state reimbursement above (ID 6.1).
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	• No.
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	• Not applicable
7.2		What percentage of hospitals are included in the State's selective contracting program?	• Not applicable
7.3	8	What services are subject to selective contracting?	• Not applicable

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ID	TASK	QUESTIONS	RESPONSES
7.4	8	What are the selective contracting payment approaches to IP services?	• Not applicable
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	• Not applicable
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	• Not applicable
7.7	8	Is a facility-wide RCC used or departmental RCCs?	• Not applicable
7.8	8	What is the source of the RCCs?	• Not applicable
7.9	8	How often are the RCCs used for payment updated?	• Not applicable
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	• Not applicable

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ID	TASK	QUESTIONS	RESPONSES
8.2	8	Describe IP Centers of Excellence programs?	• Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	• Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	• Not applicable
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	• Not applicable
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	• Not applicable
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis	• Services provided by an Inpatient Psychiatric Facility are reimbursed under the per diem methodology (per 55 PAC 1151.46). Please see the discussion of

ID	TASK	QUESTIONS	RESPONSES
		than acute medical/surgical services?	payment per diem above (ID 3.8). • Exceptions to standard per diem methodology (per 55 PAC 1163.51): – Psych services are reimbursed under a special methodology under the following circumstances: ▪ If a hospital provides services to a recipient with a psychiatric principal diagnosis but the hospital does not have a psychiatric unit that is excluded from the DRG system, the Department pays a 2-day per diem amount for the hospital stay (per 55 PAC 1163.51(n)). ▪ If a hospital provides services to a recipient with a psychiatric principal diagnosis, the hospital is reimbursed under DRG prospective payment system, an emergency situation exists, and the psychiatric unit is full, the Department will make a 2-day per diem payment (per 55 PAC 1163.51 (o)). – The special two day per diem methodology is calculated as follows: [(normal payment rate for the DRG) / (Statewide DRG Average length of stay)] x 2.
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	• Per diem. Please see the discussion of psych payment method above (ID 9.1)
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	• No (per discussion with Department). Department is considering rebasing per diem rates in the future.

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ID	TASK	QUESTIONS	RESPONSES
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	• Standard psych per diem payments are made to psych hospitals, units, and DPUs regardless of diagnosis. • Special psych payment methodology at acute settings are made for psych DRGs.
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	– If a hospital provides services to a recipient with a psychiatric principal diagnosis but the hospital does not have a psychiatric unit that is excluded from the DRG system, the Department pays a 2-day per diem amount for the hospital stay (per 55 PAC 1163.51(n)). – The special two day per diem methodology is calculated as follows: [(normal payment rate for the DRG) / (Statewide DRG Average length of stay)] x 2.
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	• No.
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	• No.
10.2		If not, does the state provide higher payment rates to children's hospitals?	• Children's Hospitals may qualify for Disproportionate Share Hospital Payments (per 55 PAC 1163.67).

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ID	TASK	QUESTIONS	RESPONSES
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	• Managed Care recipients are enrolled in the following plans (per Office of Medical Assistance Programs Website: – Pennsylvania MA benefits are provided by three programs: HealthChoices, ACCESS Plus, and Voluntary MCO. ▪ MA recipients residing in specified zones (predominately urban locations) are automatically enrolled in the mandatory HealthChoices managed care program which provides both inpatient and outpatient services for physical and mental health as well as drug and alcohol services. ▪ MA recipients residing in any of the 42 predominately rural counties which do not offer HealthChoices are automatically enrolled in the fee-for-service program called ACCESS Plus. These recipients are given and ACCESS card and the opportunity to select, or else be assigned to, a Primary Care Practitioner (PCP). ▪ ACCESS Plus MA recipients also have the option of enrolling in the voluntary program and joining one of the MA managed care health plans (MCOs) available in the MA recipient's county.
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	• Plans directly negotiate payment rates with hospitals.
		State Demographics	

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ID	TASK	QUESTIONS	RESPONSES
12.1		How many Medicaid recipients do you have?	• 1,523,673 (per Dec. '02 Kaiser Report)
12.2		What is your state's population?	• 12,365,455 (per 2003 U.S. Census Bureau)

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ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1	2	How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	AP-DRG Version 14.0
1.2	2	Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Information not provided. ▪ AP-DRG or CMS/Medicare DRG _____ % ▪ Percent of billed charges _____ % ▪ Fixed payment per case _____ % ▪ Fixed per diem _____ % ▪ Other Method _____ %
1.3	2	How are the following services paid for?	**Neonate Services** (other than normal newborn) Use the AP-DRG system. They choose this system because it has about 25 DRGs

ID	TASK	QUESTIONS	RESPONSES
			for this area compared to other competing systems. **Transplant Services** These services are exempt from the DRG based system, but no additional information was provided. **Rehab Services** Hospital specific prospective operating cost rate per day. Quarterly DSH adjustment for Medicaid/Indigent dependant hospital; additional payments for allowable costs of depreciation, capital interest, and medical education. There is an automatic update yearly according to inflation. The limit placed on payments by Medicaid is reasonable cost or usual charge. **Psych Services** Hospital specific prospective operating cost rate per day. Quarterly DSH adjustment for Medicaid/Indigent dependant hospital; additional payments for allowable costs of depreciation, capital interest, and medical education. There is an automatic update yearly according to inflation. The limit placed on payments by Medicaid is reasonable cost or usual charge. **HIV Services** By AP-DRG.
1.4	2	How are low volume AP-DRGs (those with no relative weight established) paid for?	They rebase every 3 years using their own data for those AP-DRGs which have low or no volume they substitute a NY weight.
1.5	2	What percentage of total payments do	Information not provided.

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ID	TASK	QUESTIONS	RESPONSES
		the following services represent?	Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ % AP-DRG low volume _____ %
1.6	2	Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	The state recognizes that there are costs associated with treating patients other than the direct costs of a particular patient's care. The state pays each hospital a percentage of these costs equal to the percentage of the hospitals business that is Medicaid. This type of payment is considered a "pass-through." For Direct Medical Education and Indirect Medical Education, the state provides quarterly prospective payments passed through at cost settlement. Likewise, for DSH payments, the state provides quarterly prospective payments.
1.7	2	Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	Information not provided.
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	Information not provided.

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ID	TASK	QUESTIONS	RESPONSES
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	Days Stay/Claims 1995 556,474 1996 453,337 1997 418,934 1998 397,668 1999 392,165
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	Total % Change from Prior Yr 1995 2058.2 12.7 1996 2167.1 5.3 1997 2253.8 4.0 1998 2342.5 3.9 1999 2461.7 5.1 2000 2732.4 11.0 2001 3032.5 11.0 2002 3177.9 4.8 2003 3570.0 12.3 Total is in millions.
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	There have been small changes, but no significant changes in recent years.
1.12	2	What portion of inpatient hospital payments have been made for outlier	They program for 5% but it is actually a little higher (roughly 8%).

ID	TASK	QUESTIONS	RESPONSES
		cases?	
1.13	2	What have been the payment/utilization/methods for RCC claims?	Percent of charges to adjust the actual charges. At the beginning of the year they pay 30% of charges, but this decreases throughout the year. Most years they finish paying 26% of charges.
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	AP-DRG Version 14.0
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	• Virginia uses the All-Patient Diagnosis Related Groups (AP-DRG) Grouper to classify inpatient services. • The DRG base rate is based on the hospital-specific operating rate per case, which is calculated by taking the labor portion of the statewide operating rate per case times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per case. – The statewide operating rate per case is calculated as follows, per 12VAC30-70-331: A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12VAC30-70-361, times the inflation values specified in 12VAC30-70-351 times the

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
			adjustment factor specified in subsection B of this section. B. The adjustment factor shall be determined separately for Type One [state owned teaching] and Type Two [all other] hospitals: 1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the Type One hospital statewide operating rate per case to equal the Type Two hospital statewide operating rate per case; 2. For Type Two hospitals the adjustment factor shall be the ratio of the following two numbers: a. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the base year. b. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year. – The base year standardized operating costs per case is calculated as follows, per 12VAC30-70-361: A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

ID	TASK	QUESTIONS	RESPONSES
			B. Using the data elements identified in subsection E of 12VAC30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per case: 1. The operating costs for each DRG case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12VAC30-70-221. 2. The standardized operating costs for each DRG case shall be calculated as follows: a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs. b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs. c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs. 3. The case-mix neutral standardized operating costs for each DRG case shall be calculated by dividing the standardized operating costs for the case by the hospital's case-mix index. 4. The base year standardized operating costs per case shall be calculated by summing the case-mix neutral standardized operating costs for all DRG cases and dividing by the total number of DRG

ID	TASK	QUESTIONS	RESPONSES
			cases. 5. The base year standardized operating costs per case shall be reduced by 5.1% to create a pool for outlier operating payments. Eligibility for outlier operating payments and the amount of the outlier operating payments shall be determined in accordance with 12VAC30-70-261. C. Because the current cost report format does not separately identify psychiatric costs, claims data shall be used to calculate the base year standardized operating costs per case, as well as the base year standardized operating costs per day described in 12VAC30-70-321. At such time as the cost report permits the separate identification of psychiatric costs and the DRG payment system is recalibrated and rebased, cost report data shall be used to calculate the base year standardized operating costs per case and base year standardized operating costs per day. – Operating rates are annually adjusted for inflation, per 12VAC30-70-351: Each July, the DRI-Virginia moving average values as compiled and published by DRI-WEFA, Inc., under contract with the department shall be used to update the base year standardized operating costs per case, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI-WEFA, Inc., in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

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ID	TASK	QUESTIONS	RESPONSES
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	• Per 12VAC30-70-50, hospitals are grouped according to number of beds and urban versus rural. – Three groupings for rural - 0 to 100 beds, 101 to 170 beds, and over 170 beds – Four groupings for urban - 0 to 100, 101 to 400, 401 to 600, and over 600 beds ○ Cost Per Case and Cost Per Day calculations includes Wage Index adjustments.
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	Information not provided.
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	There is no selective contracting in the state.
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	Virginia pays all hospitals according to the same AP-DRG methodology.
2.7	3	What method was used to establish relative weights?	See earlier discussion.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	They pull their own claims data every 3 years and they have outside consultants work to establish the new weights, etc.
2.9	3	How often is the AP-DRG relative weight recalibrated?	Every 3 years.

ID	TASK	QUESTIONS	RESPONSES
2.10	3	How often are conversion factors rebased, updated, or recalculated?	Every 3 years.
2.11	5	What is the payment policy when billed charges are less than DRG payment?	– Per 12VAC30-70-30, the Medical Assistance Program will not pay more in the aggregate for inpatient hospital services than customary charges.
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	• Cost outlier payments are made as follows, per 12VAC30-70-261: A. An outlier operating payment shall be made for outlier cases. This payment shall be added to the operating payments determined in 12VAC30-70-231 and 12VAC30-70-251. Eligibility for the outlier operating payment and the amount of the outlier operating payment shall be determined as follows: 1. The hospital's adjusted operating cost for the case shall be estimated. This shall be equal to the hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12VAC30-70-221, times the adjustment factor specified in 12VAC30-70-331 B. 2. The adjusted outlier operating fixed loss threshold shall be calculated as follows: a. The outlier operating fixed loss threshold shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. Hence, the nonlabor portion of the outlier operating fixed loss threshold shall constitute one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold. b. The labor portion of the outlier operating fixed loss threshold shall be multiplied by the hospital's Medicare wage index, yielding the wage

ID	TASK	QUESTIONS	RESPONSES
			adjusted labor portion of the outlier operating fixed loss threshold. c. The wage adjusted labor portion of the outlier operating fixed loss threshold shall be added to the nonlabor portion of the outlier operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold. 3. The hospital's outlier operating threshold for the case shall be calculated. This shall be equal to the wage adjusted outlier operating fixed loss threshold times the adjustment factor specified in 12VAC30-70-331 B plus the hospital's operating payment for the case, as determined in 12VAC30-70-231 or 12VAC30-70-251. 4. The hospital's outlier operating payment for the case shall be calculated. This shall be equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment shall be made. If the difference is greater than zero, then the outlier operating payment shall be equal to the difference times the outlier adjustment factor. C. The outlier operating fixed loss threshold shall be recalculated using base year data when the DRG payment system is recalibrated and rebased. The threshold shall be calculated so as to result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

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ID	TASK	QUESTIONS	RESPONSES
2.13	6	How often is the high outlier payment policy updated?	Every 3 years when rebasing occurs this policy is updated. Then every year inflation is applied to update the payment.
2.14	6	Are conversion factors and the high outlier policy updated concurrently?	Every 3 years when rebasing occurs this policy is updated. Then every year inflation is applied to update the payment.
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	Information not provided.
2.16	6	What proportion of cases are paid using the outlier methodology?	A very small number, but unsure of actual percentage.
2.17	6	Are there interim outlier payment strategies? What are they?	No.
2.18	6	What methods are used to pay for transfer cases?	The transferring hospital is paid on a per diem basis established by dividing the DRG by the average LOS for that DRG. This per diem rate is the multiplied by the number of days. The transferring hospital receives this payment rate, but it cannot receive more than the normal DRG rate. The receiving hospital received the full DRG payment rate.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	A very low number.
2.20	6	How are payments to specialty hospitals and long term care hospitals	Unsure of transfers throughout these facilities. They only have 2LTC hospitals. One is a children's hospital and the other is really a nursing home. Both are paid

ID	TASK	QUESTIONS	RESPONSES
		made when patients are transferred from acute care hospitals?	using per diem rates.
2.21	6	Is a hospital peer group conversion used? If so, how are the peer groups defined?	No peer grouping.
2.22	6	Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	No
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	No IP services are paid using RCC except for outliers.
3.2	3	For what services is the RCC methodology used?	Only outpatient services.
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	They are drawn from the cost report. Total allowed divided by charges usually equates to 25-30% of charges.
3.4	3	How often are RCCs recalculated or updated?	IP – Every 3 years OP – Every year with the percentage trending downwards.

ID	TASK	QUESTIONS	RESPONSES
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	Information not provided.
3.6	3	Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	No.
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• Summary of information below and supplemental info from interview: - The State received Medicare cost reports with 1998 data. From this they calculated the standardized operating costs per day by taking costs divided by days. This statewide rate is then adjusted each year by inflation and an adjustment factor (see below). Once, this is calculated the State then takes 76% of the costs and applies wage index values. This allows the same providers in a similar geographic region to receive similar reimbursements. • Psych services and rehab services are reimbursed via a per diem payment, based on hospital cost per day. – The hospital specific operating rate per day contains the following, per 12VAC30-70-321: A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12VAC30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day. B. The hospital specific rate per day for freestanding psychiatric cases shall

ID	TASK	QUESTIONS	RESPONSES
			be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases. C. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases. D. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals. E. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report. – The statewide operating rate per day is based on the following, per 12VAC30-70-331: A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in 12VAC30-70-361, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B of this section. B. The adjustment factor shall be determined separately for Type One and Type Two hospitals: 1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the Type One hospital statewide operating rate per case to equal the Type Two hospital statewide operating rate per

ID	TASK	QUESTIONS	RESPONSES
			day; 2. For Type Two hospitals the adjustment factor shall be the ratio of the following two numbers: a. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the base year. b. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year. – The base year standardized operating costs per day is based on the following, per 12VAC30-70-371: A. For the purpose of calculating the base year standardized operating costs per day, base year claims data for per diem cases shall be used. Base year claims data for DRG cases shall not be used. Separate base year standardized operating costs per day shall be calculated for Type One and Type Two hospitals. B. Using the data elements identified in subsection E of 12VAC30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per day: 1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12VAC30-70-221. 2. The standardized operating costs for each per diem case shall be

ID	TASK	QUESTIONS	RESPONSES
			calculated as follows: a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs. b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs. c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs. 3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases. C. For general acute care hospitals with psychiatric DPUs, the psychiatric operating cost-to-charge ratio shall be used in the above calculations. – Operating rates are annually adjusted for inflation, per 12VAC30-70-351: ▪ Each July, the DRI-Virginia moving average values as compiled and published by DRI-WEFA, Inc., under contract with the department shall be used to update the base year standardized operating costs per case, to the midpoint of the upcoming state fiscal year. The most current table

ID	TASK	QUESTIONS	RESPONSES
			available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI-WEFA, Inc., in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.
3.8	4	Describe the fixed payment per case or per diem methodology? How are payment levels determined?	Rehab & Psych use a prospective per diem , which is derived from days multiplied by the rate.
3.9	4	Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	None
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	None
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	None
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	They have discussed moving to APGs, but they are not currently in the position to do so. They have a new intermediary who is processing claims and they do not want to put additional stress on the system by changing the payment methodology. They will most likely change in the next 3 years.

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ID	TASK	QUESTIONS	RESPONSES
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	None.
		Critical Access Hospitals	
4.1	3/9	How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	2 CAH Hospitals received both state and federal certification in Virginia (Bath County Community Hospital, RJ Reynolds-Patrick County Memorial Hospital) 1 CAH Hospital received state but not federal certification in Virginia (Carilion Giles Memorial Hospital) Virginia has 68 acute care hospitals, therefore 4.4% of all VA hospitals are CAH. However, the Virginia Medicaid agency does not recognize any CAHs in terms of paying them differently.
4.2	3/9	Of total inpatient payments, what percentage do CAH payments represent?	None
4.3	3/9	What method does the state use to identify CAH hospitals?	Limit of 15 acute care beds and 10 swing beds, a length of stay averaging no more than 96 hours, a daily census of 15 acute care patients, 24-hour emergency services and agreements with a network hospital for patient referral and transfer.
4.4	3/9	How does the state pay for inpatient CAH services?	They do not pay differently.
4.5	3/9	Is the State's payment methodology for	No

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ID	TASK	QUESTIONS	RESPONSES
		CAHs different from non-CAH general acute care hospitals, and if so, how?	
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	Not applicable
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	No
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	Not applicable
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	Not applicable
4.10	3/9	Does the State perform cost settlements for CAHs?	Not applicable
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	They have recently seen a decrease in these facilities.
4.12	3/9	How many CAHs are in the state	2 recognized by federal and state, 1 recognized by state only. None recognized

ID	TASK	QUESTIONS	RESPONSES
		currently?	for different payments by DMAS.
		Trauma Services	
5.1	9	How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	13 hospitals in VA are designated trauma centers. This constitutes 19% of the 68 acute care hospitals in the State.
5.2	9	Of total inpatient payments, what percentage do payments to trauma centers represent?	Information not provided.
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	None.
5.4	9	Does the State make special payments for Medicaid trauma care services?	No. This is a large problem for trauma facilities in Virginia. On average, a trauma facility loses $3,000 per Medicaid patient they treat because of inadequate reimbursement levels. The centers must recoup these losses by treating patients with private insurance since they also lose money by treating Medicare patients.
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	Not applicable.
5.6	9	What is the specific methodology used to determine payment?	Not applicable.

ID	TASK	QUESTIONS	RESPONSES
5.7	9	How often are these payments made?	Not applicable.
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	Not applicable.
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	Information not provided.
5.10	9	What are these specific diagnosis or procedure codes?	Information not provided.
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	They do not.
5.12	9	How have the volume of trauma care services and Medicaid trauma care payments changed over time?	Information not provided.
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	Information not provided.
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		used for the uninsured)?	
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	Information not provided.
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	8-10 border hospitals that are located primarily in NC, TN and DC. If they have 1500 days/year or more they can request to be treated as an in-state facility but most do not because of the data reporting requirements.
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	No.
6.3	3	If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	No
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	For OP services; the same as in-state hospitals are paid.
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	With some out of state specialty hospitals, but this is a very rare occurrence. It only happens once or twice per year.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Virginia Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
7.2	8	What percentage of hospitals are included in the State's selective contracting program?	1 or 2 a year.
7.3	8	What services are subject to selective contracting?	None
7.4	8	What are the selective contracting payment approaches to IP services?	None
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	On a case by case basis.
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	Not applicable
7.7	8	Is a facility-wide RCC used or departmental RCCs?	Not applicable
7.8	8	What is the source of the RCCs?	Not applicable
7.9	8	How often are the RCCs used for payment updated?	Not applicable

Washington State Medicaid
Inpatient Hospital Rebasing Project
Virginia Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	No
8.2	8	Describe IP Centers of Excellence programs?	Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	Not applicable
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	Not applicable
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-	Not applicable

ID	TASK	QUESTIONS	RESPONSES
		transplant services?	
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	They pay using a prospective per diem.
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	Prospective per diem
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	No
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	Primary diagnosis of psychiatric ailment.
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	They pay using a prospective per diem and the patient is identified if they have a primary diagnosis of a psychiatric ailment.
9.6	7	Is an organization such as Regional	They are not aware of this.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Virginia Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Support Networks used for paying inpatient psych claims?	
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	No.
10.2		If not, does the state provide higher payment rates to children's hospitals?	The Children's hospital in the state get a significant amount of DSH money, but otherwise they do not have a higher rate or additional payments.
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	When a person becomes eligible for Medicaid, they are classified into a certain aid category using income and other factors. Every person who is in an aid category deemed eligible for Medicaid is then enrolled into one of the HMOs in a certain area (usually 4-5 in each state region). The algorithm looks for history or family history with any HMO and keeps families together. The enrollee can choose to switch after one month to another HMO.
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	Each plan individually negotiates rates by themselves.
		State Demographics	

Washington State Medicaid
Inpatient Hospital Rebasing Project
Virginia Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
12.1		Ho many Medicaid recipients do you have?	606,115 as of July 1, 2004
12.2		What is your state's population?	7,386,330 estimated as of 2003

Washington State Medicaid
Inpatient Hospital Rebasing Project
Wisconsin Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1	2	How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	The Wisconsin Medicaid Program (WMP) uses a reimbursement system which is based on Diagnosis Related Groups (DRGs). The DRG system covers acute care hospitals and hospital institutions for mental diseases (IMDs). Excluded from the DRG system are rehabilitation hospitals, State IMDs, and State veterans hospitals which are reimbursed at rates per diem. Also, reimbursement for certain specialized services are exempted from the DRG-system. These include AIDS, ventilator-assisted patients, unusual cases and brain injury cases. Organ transplants are covered by the DRG system. DRG's are customized to some extent.
1.2	2	Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	Estimated to be: ▪ AP-DRG or CMS/Medicare DRG ____85_____ % ▪ Percent of billed charges _____ % ▪ Fixed payment per case _____ % ▪ Fixed per diem _____15_____ % ▪ Other Method _____ %
1.3	2	How are the following services paid for?	**Neonate Services** (other than normal newborn)

ID	TASK	QUESTIONS	RESPONSES
			WMP has enhanced the grouper's MDC 15. **Transplant Services** In order for a hospital to receive payment for transplant services, the following criteria must apply: a. The transplant must be performed at an institution approved by the WMAP for the type of transplant provided. b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval. c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization. *Transplant Log*. Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMAP recipient (except bone marrow) indicating the organ procurement organization or agency or source of the organ and all costs associated with procurement. A copy of this log must be submitted along with the transplant hospital's Medicaid cost report, so that the WMAP may document compliance. **Rehab Services** The following is the methodology to be followed for calculating a per diem payment rate for rehabilitation hospitals which are not new rehabilitation

ID	TASK	QUESTIONS	RESPONSES
			hospitals. 1) The Medicaid allowable costs from the audited cost reports for the hospitals' three base cost reporting years shall be indexed to June 30th of the earliest year of the three years by the DRI/McGraw Hill, Inc. CMS Hospital Market Basket inflation rate. The "three base cost reporting years" for a hospital shall be the hospital's fiscal years which ended in the second, third and fourth calendar years preceding the calendar year of each annual rate update (defined §3000). If needed audited cost reports are not available prior to a new rate year in order to calculate the annual rate update, then an interim rate shall be established for the new rate year until the audited cost reports are available. 2) Divide the total direct medical education costs for the three years by the total hospital costs for the three years to get the average percentage of direct medical education costs. 3) Divide the total capital related costs for the three years by the total hospital costs for the three years to get the average percentage of capital costs. 4) Multiply the total Medicaid allowable costs (step 1) by the percentage of direct medical education costs (step 2) to arrive at Medicaid direct education costs. 5) Multiply the total Medicaid allowable costs (step 1) by the percentage of capital costs (step 3) to arrive at Medicaid capital costs. 6) Subtract the Medicaid education costs (step 4) and the Medicaid capital cost (step 5) from the total Medicaid costs (step 1). 7) Multiply the Medicaid capital costs (step 5) by . 95. 8) Add the Medicaid costs (step 6), the Medicaid direct medical education costs (step 4) and the reduced capital cost (step 7). This is the total adjusted Medicaid

ID	TASK	QUESTIONS	RESPONSES
			costs. 11) Divide the adjusted Medicaid costs (step 8) by the total Medicaid days from the three audited cost reports to get an adjusted Medicaid cost per diem. 11) Index the adjusted Medicaid cost per diem by the legislatively authorized increases through the current rate year and increase the per diem by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5240. **Psych Services** WMP has enhanced the grouper's MDC 19. The WMP has expanded the nine standard DRGs of this MDC and for each of the DRGs, separate weighting factors are constructed for two age ranges: over age 17 and age 17 and younger. The result is 18 weighting factors. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals and in hospital institutions for mental disease (IMD) except Milwaukee County Mental Health Center. A separate schedule of 18 DRG weighting factors are constructed for the Milwaukee County Mental Health Center for hospital stays classified to MDC 15. Weights are calculated as described above using average cost by DRG for hospital stays in the MCMHC that are classified to MDC 15. Reimbursement for inpatient hospital services will be a final reimbursement settlement for each hospital's fiscal year based on the hospital's allowable cost incurred in its fiscal year. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided. **Interim Rate Per Diem**

ID	TASK	QUESTIONS	RESPONSES
			Patient stays in a hospital covered by this section will be paid at interim or temporary rates per diem until a final reimbursement settlement can be completed for the hospital's fiscal year. The interim rate effective in a rate year, July to June, will be based on the interim rate per diem paid on June 30 of the prior rate year excluding any disproportionate share adjustment of section 5240. (The rate paid on the June 30 prior to the effective date of this change in reimbursement methodology will be the base for the interim rate effective on the effective date of this change.) The June 30 rate will be adjusted by the inflation multiplier from section 27200 that is listed under the fiscal year end date that coincides with the above June 30 date. The result will be increased by any disproportionate share adjustment for which the hospital may qualify under section 5240. The resulting interim rate will be increased if the hospital justifies an adjustment based on its historical expenses or expected expenses. The Department may at any time decrease the interim rate if it determines federal upper payment limits may be exceeded **Final Reimbursement Settlement** After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid inpatient services during its fiscal year will be determined from the hospital's audited Medicaid cost report for the fiscal year. Allowable costs will include the net direct costs of education activities incurred by the hospital as determined according to 42 CFR δ413.85. Covered education activities include those allowed under δ413.85 and approved residency programs, allowed under 42 CFR δ413.86, in medicine, osteopathy, dentistry and podiatry.

ID	TASK	QUESTIONS	RESPONSES
			A disproportionate share hospital (DSH) adjustment will be determined according to section 5240 if the hospital meets the qualifying criteria of that section. The DSH adjustment percentage will be applied to the allowable cost of Medicaid inpatient services for the fiscal year to determine the hospital's DSH payment. To calculate the adjustment percentage, the formulae and related fixed variables of section 5240, that were in effect on the July 1 date in the hospital's fiscal year, will be applied to the patient utilization incurred by the hospital in its fiscal year. The final reimbursement settlement will take the following federal payment limits into consideration: • Total final reimbursement may not exceed charges according to section 9000. • Compliance with the federal upper payment limit of 42 CFR δ447.272, also know as the Medicare upper-limit, will be retrospectively determined when the final settlement is determined. If necessary, final reimbursement will be reduced in order that this federal upper payment limit is not exceeded. • The hospital's disproportionate share payment may not exceed the limits of section 9100 which will be determined based on the hospital's fiscal year cost report used for the final settlement. • Disproportionate share payment in the final reimbursement will be reduced, if necessary, to not exceed the State's limitations on aggregate payments for disproportionate share hospitals under 42 CFR 447.297. If the total amount of final reimbursement, including DSH payment, for the hospital's fiscal year exceed the total interim payments for the year, then the difference will be paid to the facility. The difference will be recovered if the total final reimbursement, including DSH payment, is less than the total interim payments.

ID	TASK	QUESTIONS	RESPONSES
			The above reimbursement methodology is being implemented effective on a date that might not be the beginning date of a covered hospital's fiscal year. In such a case, the hospital's Medicaid allowable cost for its full fiscal year will be prorated between the months not covered and months covered by this reimbursement methodology based on the number of Medicaid inpatient days in each period. **HIV Services** The current payment rates per diem for AIDS acute care and for AIDS extended care are listed in section 7900. These per diem rates apply for instate hospitals, major and minor border-status hospitals and non-border status hospitals. Total payment is calculated as the sum of the acute care per diem times the number of approved acute care days plus the extended care per diem times the number of approved extended care days. Payment will not exceed total covered charges. AIDS cases paid under the per diem rate of this section do not qualify for outlier payments. AIDS reimbursement rates are not subject to administrative adjustment. **Acute Care**. Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria apply: a. The patient must have an established diagnosis of AIDS. b. Clinical findings and other relevant medical information must substantiate the medical necessity and appropriateness of the hospitalization and its payment at the AIDS acute care rate.

ID	TASK	QUESTIONS	RESPONSES
			c. Medical record documentation supporting the medical necessity and appropriateness of acute inpatient care must be submitted with the request for approval. Approval for the acute care per diem is granted for a specified period of time. If the patient still meets the intensity and severity criteria for acute care, the provider must submit a subsequent request for extension of the payment approval. **Extended Care**. Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria must be met: a. The patient must have an established diagnosis of AIDS. b. The patient must be medically stable per discharge indicators appropriate for the system involved. c. The patient must require infection control procedures and isolation techniques. d. Reasonable attempts at securing alternative living situations that allow for correct infection control procedures and isolation techniques must have been unsuccessful and an appropriate plan of care and discharge plan must have been established. e. The degree of debilitation and amount of care required must equal or exceed the level of skilled nursing care provided in a nursing facility (NF). f. Sufficient documentation supporting these criteria must be submitted with the request for approval. Approval for the extended care rate is granted for a specified period of time, after which if the patient still meets the intensity and severity criteria for extended care, the provider must submit a subsequent request for extension of the payment approval. The progression of illness may require acute care services during the period established for extended care. Therefore, during an "extended care" period, the acute care payment rate will be approved

ID	TASK	QUESTIONS	RESPONSES
			for payment after the hospital has provided an acute level of care for at least five days and the WMAP determines the above acute care criteria are met.
1.4	2	How are low volume AP-DRGs (those with no relative weight established) paid for?	Uses established DRG rates (on a 3 year basis of claims); when necessary, individual DRG adjustments are made.
1.5	2	What percentage of total payments do the following services represent?	Information unavailable at time of call. Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ % AP-DRG low volume _____ %
1.6	2	Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	The EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the EACH supplement is limited to the amount that is listed in Appendix Section 27100. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals. A qualifying hospital's EACH supplement will be determined as follows: Hospital's Annual EACH Supplement = Medicaid days for hospital/ Sum of Medicaid days of qualifying hospitals X Statewide Annual Funding The monthly amount is the above annual amount divided by 12 months. The

ID	TASK	QUESTIONS	RESPONSES
			annual statewide funding for the essential access city hospital (EACH) disproportionate share hospital adjustment is $4,748,000. Medicaid days are a hospital's total covered inpatient days for Medicaid recipients for the calendar year prior to the rate year for which the EACH supplement is being calculated. The days include Medicaid HMO covered days and Medicaid covered days on which Medicaid made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of Medicaid recipient stays that are covered in full or part by Medicare. **Calculation** Effective July 1, 2004, a hospital's disproportionate share adjustment factor under section 5243 is calculated according to the following formula where: 17.10% = Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate. M = The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than 17.10%. .26 = Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases. *Formula:* [(M -17.10%) x .26] + 3% = Hospital's Specific Disproportionate Share]. For the rate year July 1, 2004 through June 30, 2005, and each rate year thereafter, the maximum available funding for the general assistance disproportionate share hospital allowance (GA-DSH) under section 8200 is $32,921,171.

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Inpatient Hospital Rebasing Project
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ID	TASK	QUESTIONS	RESPONSES
1.7	2	Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	Information not provided.
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	This is not tracked.
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	Inpatient Days per 1,000 Population: 1999 - 647; 2000 - 620; 2001 - 639; 2002 - 624. *Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included. Calculation based on 1999, 2000, 2001, and 2002 AHA Annual Surveys.*
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	As with all states, case load has increased. Total dollar amount have not changed significantly because rates are established prospectively. The cost of care has increased and the payment as percentage of cost has decreased.
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	No.
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
1.13	2	What have been the payment/utilization/methods for RCC claims?	RCC not recognized.
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	The Wisconsin Medicaid DRG reimbursement system uses the Centers for Medicare and Medicaid services (CMS) DRG Grouper developed for and used by Medicare, with enhancements for newborn DRGs and mental disease and disorder DRGs. The grouper that is effective for Medicare on October 1st becomes the current effective grouper for Medicaid the following July 1st. For example, Medicare implemented grouper version 18 on October 1, 2000 and Wisconsin Medicaid began using grouper version 18 on July 1, 2001.
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	• The DRG base rate standardized amounts are called "Standard DRG Group Rates". The standardized amounts are calculated as follows: – Standard DRG group rates were based on the level of expenditures made to hospitals for WMP inpatient stays in calendar year 1989. Subtracted from these expenditures were (a) payments to hospitals for services not included in the DRG payment system such as, but not limited to, ventilator-assisted patients and AIDS patients' services; (b) capital payments; (c) direct medical education payments; (d) indirect medical education payments; (e) disproportionate share adjustment payment; and (f) outlier payments. The amount was further reduced by the extra expenditures attributable to HMO

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

ID	TASK	QUESTIONS	RESPONSES
			adverse selection that was 10%of the expenditure for cases in Milwaukee County. The resulting net expenditure amount divided by hospital stays from 1989 generated a statewide average base expenditure. (The number of hospital stays used excluded the stays covered by non-DRG PAYMENTS described in item (a) above.) – The net IMD hospital expenditures per case were found to differ significantly from statewide average expenditures. This difference was recognized by establishing separate rates for IMD hospitals and general medical and surgical hospitals. – The statewide average base expenditure is adjusted annually according to funding amounts authorized through the State's biennial budget process. – Enrollment in the HMO Preferred Enrollment Initiative (PEI) has been mandatory for over ten years for Milwaukee County Medicaid recipients in certain medical status categories such as those for children and mothers. WMP recipients not mandated for HMO coverage are in general, but not limited to, aged and disabled. Because the non-HMO, fee-for-service Medicaid population in Milwaukee requires more intensive medical care and is more costly to care for than the fee-for-service Medicaid population in other counties, the standard DRG group rates will be 10% greater for Milwaukee County hospitals than for hospitals in other counties to allow for any HMO adverse selection occurring in Milwaukee. If the HMO/PEI ceases to be mandatory in Milwaukee County, the WMAP will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates. A specific hospital may request an administrative adjustment under section 11900, item I, "Adjustment for PEI Ceasing to be Mandatory.".

ID	TASK	QUESTIONS	RESPONSES
			– Based on the analysis described in the above discussion, separate base rates are provided for the following four groups of hospitals. Four group rates allow for (1) the difference described above for general medical and surgical hospitals and IMD hospitals and (2) the difference caused by HMO adverse selection described above. The result, standard DRG rate for each of the following four groups. ▪ General Medical and Surgical Hospitals in Milwaukee County ▪ General Medical and Surgical Hospitals not in Milwaukee County ▪ Hospital IMDs in Milwaukee County ▪ Hospital IMDs not in Milwaukee County
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	• Hospital specific DRG base include a wage index adjustment based on the hospital's labor market: Each hospital is assigned a unique "hospital-specific DRG base rate". This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount, based on the hospital's historical costs, for capital for direct costs of medical education programs. For some hospitals, the rate also includes additional amounts for a serving a disproportionate share of low-income persons or for the hospital being located in a rural area. • Wage Indices are assigned based on the Medicare MSA classification system. Wage areas are identified by the metropolitan statistical areas (MSAs) and the rural areas which are used by HCFA in the Medicare program as of March 31 prior to the beginning of each rate year. These wage areas in Wisconsin are defined by the counties in each wage area. The Milwaukee MSA includes four counties. The Department has divided the Milwaukee MSA into two wage

ID	TASK	QUESTIONS	RESPONSES
			areas, a Milwaukee county only wage area and an Ozaukee-Washington-Waukesha counties' wage area. A statewide average wage rate will be calculated using wage data from WMAP certified hospitals located in Wisconsin. The average wage index for each wage area shall be the ratio of the average wage for the respective wage area to the statewide average wage. The statewide rate, in essence, has a 1.00 index. The average statewide and area wage rates shall be the average of individual hospitals' average wage weighted by the individual hospitals' amount of staff. As a result, larger hospitals will have a greater impact on the statewide and area average wage rate than smaller hospitals. For each area three indices will be calculated: (1) a "composite" index which includes wages for the original remaining hospitals and the hospitals re-classified to the wage area (2) an "original remaining hospitals" index based on wages of only the original remaining hospitals in a wage area and (3) a "reclassified hospitals" index based on wages of only the hospitals reclassified to the wage area. • Rural Wage Area Indices The wage index for the Wisconsin rural area will be based on wage data for only the original remaining hospitals in the rural area and will not include hospitals reclassified from or to the Wisconsin rural area. The wage index for the rural areas of other states will be based on wage data for only the original remaining hospitals in the rural area which are WMAP border status hospitals. • Determining Applicable Index:

ID	TASK	QUESTIONS	RESPONSES
			If the composite index is significantly lesser than the index for the original remaining hospitals in the wage area, then the index for the original remaining hospitals will be applied only to the originally remaining hospitals in the wage area. The reclassified hospitals' index will be applied only to hospitals reclassified to the wage area. Significantly lesser means the composite index for a wage area is lower than the index of original remaining hospitals in the wage area by an amount exceeding 1% of the index for the original remaining hospitals in the wage area. • Certain rural hospitals may receive a Rural Hospital Adjustment Percentage: A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Administrative adjustments regarding qualifying for the rural hospital adjustment and the adjustment percentage are described in section 1 1900, items K, L and M. Critical access hospitals under section 5900 are not eligible to receive an adjustment under this section. 1. The hospital is located in Wisconsin, is not located in a HCFA defined metropolitan statistical area (MSA) and has the WMP's Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate. 2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare. 3. The hospital is not classified as a Rural Referral Center by Medicare. 4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index. 5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or

ID	TASK	QUESTIONS	RESPONSES
			greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to *or* greater than 55.0%. For criteria item 1 above. The reclassification to an urban wage area, of a hospital which is located in a rural wage area, shall be rescinded by the Department if the urban wage area index to be applied to the hospital is lesser than the rural hospital adjustment. This allows the hospital to receive the urban wage adjustment or the rural hospital adjustment, whichever is greater. (Reference section 5226.) For criteria item 4 above. The statistical year for total discharges excluding newborns will be the fiscal year *of* the hospital. The statistical year for the Wisconsin Medicaid case-mix index will be the state fiscal year. The Statistical year for the Medicare case-mix index will be the federal fiscal year. The fiscal year to be used is that fiscal year which ended in the second calendar year preceding the annual July 1 rate update. (For example, for July 1, 1996 rate updates, the statistical years will be fiscal years that ended in 1994.) Urban hospital means any hospital located in Wisconsin which is located in a HCFA defined metropolitan statistical area (MSA) which has a WMAP urban area wage index used in calculation of its hospital-specific DRG base rate. For criteria item 5 above: The combined Medicare and Medicaid utilization rate is determined by dividing the total Medicare and Medicaid inpatient days by the total inpatient days. Long-term care days from hospital swing-beds shall not be included as inpatient days in this calculation. The inpatient days will be from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the

ID	TASK	QUESTIONS	RESPONSES
			April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old. the hospital may request an administrative adjustment under 51 1900, item *6,* to have its rural adjustment based on a more current audited cost report. For the base cost reports to be used for hospitals combining operations, see section 5860. • Certain rural hospitals may receive a Rural Hospital Adjustment Percentage, per Adjusted State Plan Attachment 4.19a – 5262. This is separate from hospital DSH payments. The amount of the rural hospital adjustment will be based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by total inpatient days from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Long-term care days from hospital swing-beds shall not be included as inpatient days in the denominator of this calculation.
2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	*Base Cost Report.* For hospitals located in Wisconsin, the direct medical education payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

ID	TASK	QUESTIONS	RESPONSES
			No Audited Cost Report Available. For hospitals located in Wisconsin for which there is no audited cost report available, an estimated direct medical education payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The direct medical education payment will be adjusted retrospectively when an audited cost report becomes available to the Department. *Calculation.* 1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs. 2. The resulting amount is inflated through the rate year by the DRI/McGraw Hill, Inc. CMS Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital. 3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report. 4. The resulting amount per discharge is divided by the average DRG case mix index per discharge. For rate year July 1, 2004 through June 30, 2005, the result is also multiplied by budget factor of 1.00. 5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210. Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.

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ID	TASK	QUESTIONS	RESPONSES
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	No selective contracting.
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	No.
2.7	3	What method was used to establish relative weights?	Wisconsin Medicaid applies the Medicare grouper and its enhancements to Wisconsin -specific claims data to establish a relative weight for each of over 600 DRGs based on statewide average hospital costs. These weights reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	Revised DRG weights will be established based on the updated version of the Medicare grouper, more current claims information, and more current inpatient hospital cost report information.
2.9	3	How often is the AP-DRG relative weight recalibrated?	Wisconsin Medicaid DRG rates and weights are updated annually and published following enactment of state budget legislation. According to federal regulations, Wisconsin Medicaid provides public notice and an opportunity for written, public comments regarding the proposed hospital reimbursement methodology, inpatient hospital rates and weights prior to final approval by the Department of Health and Family Services.

ID	TASK	QUESTIONS	RESPONSES
2.10	3	How often are conversion factors rebased, updated, or recalculated?	DRG weights are revisited every 3 years.
2.11	5	What is the payment policy when billed charges are less than DRG payment?	Aggregate hospital payments are to exceed aggregate charges for a fiscal year, per State Plan attachment 4.19a – 9000:
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	A "cost outlier" payment are made when patient costs exceed the "trimpoint", per State Plan attachment 4.19a – 5320: – Qualifying Criteria for a Cost Outlier Payment. For a hospital's claim to qualify for cost outlier payment, the following criteria apply: The charges for a given case must be usual and customary. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows for discharges on and after July 1, 1992. ----- Trimpoint Amount ----- Type of Hospital — Bed Size Less than 100 Beds 100 Beds or Greater General Medical *8* Surgical Hospitals — $ 5,235

ID	TASK	QUESTIONS	RESPONSES
			$31,410 Hospital Institutions for Mental Disease (IMDs) $ 5,460 $31,633 Hospital stays for which payment is not provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to, cases treated at rehabilitation hospitals and State-operated IMDs exempt from DRGs. cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment. – Charges Adjusted-To-Cost. ▪ For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. For cost reports to be used for combining hospitals, see $5860.For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department gets an audited cost report.

ID	TASK	QUESTIONS	RESPONSES
			▪ For Major Border Status Hospitals. For a border-status hospital, the Department shall determine a cost-to-charge ratio applicable to inpatient services provided based on the hospital's most Wisconsin Medicaid recipients by the hospital recent audited cost report on file with the Department as of the April30th prior to the annual rate update. However, the Department may, at its option, use an audited the cost report on cost report it receives later if the end date f the period of file with the Department as of the April 30th rate year by more than three years, date precedes the beginning date of the three months. Cost reporting requirements are described in 54022. For cost reports to be used for combining hospitals, see 55860. If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average Wisconsin state-wide cost-to-charge ratio which is the ratio of the total Wisconsin state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost – Outlier Payment Calculation. Variable costs in excess of the DRG payment and the trimpoint will be paid. Following are the steps for calculation of an outlier payment. An example of a cost outlier calculation is presented in appendix section 24500. 1. Allowed claim charges are adjusted to cost by multiplying the charges by the hospital's cost-to-charge ratio. 2. The allowed excess claim costs will be calculated by subtracting the DRG payment and the hospital's trimpoint from the claim costs. (Claim cost-DRG payment -Trimpoint = Excess cost, must be positive to qualify).

ID	TASK	QUESTIONS	RESPONSES
			3. The outlier payment will be the result of multiplying the excess claim costs by the variable cost factor of 77%. The variable cost factor for burn cases will be 97%. If the hospital is a disproportionate share hospital, the variable cost will be increased by 77% of the hospital's disproportionate share adjustment. – Bed Count, Source and Changes. For rate years beginning on and after July1, 1992, the trimpoint amount for each hospital shall be established effective July 1 of the rate year based on the bed count on file with the Department's Division of Health, Bureau of Quality Compliance, as of July 1 of the respective rate year. The hospital may request an administrative adjustment under section 11900, item A, to correct errors by the Department in establishing the appropriate trimpoint. If a hospital changes its bed count after July1, any change in the trimpoint amount will not be effective until July 1 of the subsequent rate year. The hospital must provide written notice of its change in bed count to the Bureau of Quality Compliance in sufficient time that the notice is received by the Bureau on or before July1of the rate year. The hospital should, but is not required to, provide a copy of the notice of the change to the Department's Division of Health, Bureau of Health Care Financing. • A length-of-stay outlier payment is available upon a hospital's request for children patients, per State Plan attachment 4.19a – 5330: – Qualifying Criteria - For a hospital's claim to qualify for length of stay outlier payment, the following criteria apply: ▪ For disproportionate share qualifying hospitals (under section 5240): 1. The hospital qualified for a disproportionate share adjustment at any

ID	TASK	QUESTIONS	RESPONSES
			time during the period of the stay, and 2. The claim is for inpatient services for a child show as under six years of age on date of discharge, and 3. For discharges on and afterJuly1, 1994, the length of the child's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.) ▪ For all hospitals: 1. The claim is for inpatient services for an infant who was under one Year of age on date of discharge, and 2. For discharges on and after July 1, 1994, the length of the infant's stay exceeds 75days (threshold days). (Prior to 7/1/94 the threshold was 114 days.) – Calculation of Length-of-Stay Outlier Payment. The claim charges will be adjusted to cost pursuant to paragraph 5320.2 above. The cost will be divided by the length of the stay to determine the cost per day. To calculate variable costs, the cost per day will be multiplied by *7796* plus 77% of the disproportionate share percentage. The resulting variable cost per day will be multiplied by the number of days which exceed the threshold days to determine the outlier payment to be made. If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital. A cost outlier payment is made when the cost of providing a service exceeds a pre-determined trimpoint. Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children

ID	TASK	QUESTIONS	RESPONSES
			under age one in all hospitals. A payment rate per inpatient discharge will be calculated for and assigned to each hospital by the Department of Health and Family Services for the rate year. This calculation determines a unique "hospital-specific DRG base rate" for each hospital. This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount for capital costs and, for qualifying hospitals, additional amounts for serving a disproportionate share of low-income persons, for direct and indirect costs of a medical education program, or for the hospital being located in a rural area. The Wisconsin Medicaid payment to a hospital for the stay is determined by multiplying the hospital's specific DRG base rate by the weight assigned to the DRG into which the stay is classified by the grouper.
2.13	6	How often is the high outlier payment policy updated?	See above.
2.14	6	Are conversion factors and the high outlier policy updated concurrently?	See above.
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	See above.
2.16	6	What proportion of cases are paid using the outlier methodology?	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
2.17	6	Are there interim outlier payment strategies? What are they?	Outlier interim payments for long length of stay are as follows, per the Wisconsin Provider manual: – Hospitals may interim bill for DRG claims if the recipient has been an inpatient at the hospital for more than 120 days. Submit claims for interim payment with patient status code "30" (still a patient) in Item 22 of the UB-92 claim form. To receive final payment for the claim, submit an adjustment to the original claim. Refer to the Claims Submission section of the All-Provider Handbook for more information on how to submit claims adjustments. – If additional interim payments are necessary, use an adjustment form for the subsequent requests. At least 30 additional days are required to elapse since the "through" date on any previous claim or adjustment. Write "interim payment for long length of stay" as the adjustment reason. Attach an updated UB-92 claim form to the request. On the updated UB-92 claim form include: ▪ A current patient status code in Item 22. ▪ All accumulated charges since admission (not just the additional charges since the first interim payment). ▪ All other updated information showing all events up to the "through" date on the claim (e.g., additional surgical procedure codes, new discharge diagnosis).
2.18	6	What methods are used to pay for transfer cases?	Patient transfers may be reviewed by WIPRO or the Department for medical necessity. If the transfer is determined to have been medically necessary, then both the transferring and the receiving hospital will be paid the full DRG amount for their discharge.

ID	TASK	QUESTIONS	RESPONSES
			An inpatient at an IMD may transfer to an acute care general hospital for a short term stay, then return to the IMD and eventually be discharged from the IMD. If the person's absence from the IMD is due to the person being an inpatient of one or more acute care hospitals for a period of three or less consecutive days, the IMD will not be paid a separate DRG discharge payment for the transfer to the acute care hospital. If the absence is for a period exceeding three consecutive days, the IMD will be paid a separate DRG discharge payment for the transfer to the acute care hospital. Three or less consecutive days means the patient is absent or on-leave from the IMD for three or less successive midnight census counts of the IMD. The IMD will be eligible for a DRG based discharge payment upon the eventual discharge of the patient from the IMD. The acute care hospital, to which the patient was transferred, will be reimbursed for the medically necessary stay without regard to the patient's length of the stay in the acute care hospital. Any payment to the IMD for a person's inpatient stay is subject to the person being eligible for MA coverage for their stay in the IMD.
2.19	6	What is the proportion of payments and cases for which transfer payments are made?	Information not provided.
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	See above.
2.21	6	Is a hospital peer group conversion used? If so, how are the peer groups defined?	Peer grouping is used when establishing DRG-based rates.

ID	TASK	QUESTIONS	RESPONSES
2.22	6	Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	No
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	RCC not recognized.
3.2	3	For what services is the RCC methodology used?	Not applicable
3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	Not applicable
3.4	3	How often are RCCs recalculated or updated?	Not applicable
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	Not applicable
3.6	3	Is there a cap for the "Allowable Room	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		Rate Charge" or "Room Rate Charge"?	
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	• The following are excluded from the DRG system and are paid under a hospital-specific daily rate: – Rehabilitation hospitals. – State-operated IMD hospitals. – State-operated veteran's hospitals • Per Diem rates for State Mental Health Institutes are as follows, per State Plan attachment 4.19a – 6200 through 6220: – Reimbursement for inpatient hospital services will be a final reimbursement settlement for each hospital's fiscal year based on the hospitals allowable cost incurred in its fiscal year. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided. Professional services described in section 6480 may be included in the final reimbursement settlement if a waiver or variance is approved under the procedures described in section 6258. – INTERIM RATE PER DIEM: Patient stays in a hospital covered by this section will be paid at interim or temporary rates per diem until a final reimbursement settlement can be completed for the hospital's fiscal year. The interim rate effective in a rate year, July to June, will be based on the interim rate per diem paid on June30 of the prior rate year excluding any disproportionate share adjustment of section 5240. (The rate paid on the June 30 prior to the effective date of this change in reimbursement methodology will be the base for the interim rate effective on the effective date of this change.) The June 30 rate will be adjusted by the inflation multiplier from section27200 that is listed under the fiscal year end date that coincides with

ID	TASK	QUESTIONS	RESPONSES
			the above June30 date. The result will be increased by any disproportionate share adjustment for which the hospital may qualify under section 5240. The resulting interim rate will be increased if the hospital justifies an adjustment based on its historical expenses or expected expenses. The Department may at any time decrease the interim rate if it determines federal upper payment limits may be exceeded. – FINAL REIMBURSEMENT SETTLEMENT: After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid inpatient services during its fiscal year will be determined from the hospital's audited Medicaid cost report for the fiscal year. Allowable costs will include the net direct costs of education activities incurred by the hospital as determined according to 42 CFR (i413.85. Covered education activities include those allowed underM13.85 and approved residency programs, allowed under 42CFR 6413.86, in medicine, osteopathy, dentistry and podiatry. • Per Diem rates for rehab hospitals are as follows, per State Plan attachment 4.19a – 6310: 1. The Medicaid Allowable cost from the audited cost reports for the hospitals' three base cost reporting years shall be indexed to June 30th of the earliest year of the three years by DRI/McGraw Hill, Inc. HCFA Hospital Market Basket Inflation Rate. The "three base cost reporting year" for a hospital shall be the hospital's fiscal years which ended in the second, third, and fourth calendar years preceding the calendar year of each annual rate update (defined in section 3000). (For example, for a July 1, 1992 annual rate update, the three base cost reporting years are a hospital's fiscal years which ended in 1990, 1989, 1988 with cost being indexed to

ID	TASK	QUESTIONS	RESPONSES
			June 30, 1988, the earlier year of the three base years. If needed audited cost reports are not available prior to a new rate year in order to calculate the annual rate update, then an interim rate shall be established for the new rate year until the audit5ed cost reports are available. 2. Divide the total direct medical education costs for the three years by the total hospital costs for the three year to get the average percentage of direct medical education costs. 3. Divide the total capital related costs for the three years by the total hospital costs for the three year to get the average percentage of capital costs. 4. Multiply the total Medicaid allowable costs (step 1) by the percentage of direct medical education costs (step2) to arrive at Medicaid direct education costs. (steps 5 through 10) 5. Multiply the total Medicaid allowable costs (step1) by the percentage of capital costs (step 3) to arrive at Medicaid capital costs. 6. Subtract the Medicaid education costs (step4) and the Medicaid capital cost (step5) from the total Medicaid costs (step 1). 7. Multiply the Medicaid capital costs (step 5) by .95. 8. Add the Medicaid costs (step 6), the Medicaid direct medical education costs (step 4) and the reduced capital cost (step 7). This is the total adjusted Medicaid costs. 9. Divide the adjusted Medicaid costs (step to get 8) by the total Medicaid days from the three audited cost reports an adjusted Medicaid cost per diem. Index the adjusted Medicaid cost per diem by the legislatively authorized increases through the current rate year and increase the per diem by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5240.

ID	TASK	QUESTIONS	RESPONSES
3.8	4	Describe the fixed payment per case or per diem methodology. How are payment levels determined?	See above.
3.9	4	Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	See above.
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	Information not provided.
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	Information not provided.
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	Information not provided.
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	Information not provided.
		Critical Access Hospitals	

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ID	TASK	QUESTIONS	RESPONSES
4.1	3/9	How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	There are 52 designated Critical Access Hospitals in Wisconsin.
4.2	3/9	Of total inpatient payments, what percentage do CAH payments represent?	Less than 10%. CAH inpatient business is very low.
4.3	3/9	What method does the state use to identify CAH hospitals?	Federal certifications.
4.4	3/9	How does the state pay for inpatient CAH services?	• Critical Access Hospitals are reimbursed as follows, per State Plan attachment 4.19a – 5900: Definition: A critical access hospital (CAH) is a hospital that meets the requirements under42 CFR Part 485, Subpart F and is designated as a critical access hospital by HCFA, and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department. Calculation of Reimbursable Critical Access Hospital Cost: A critical access hospital's costs will be audited for a fiscal year to determine the cost of providing inpatient hospital services for Medicaid recipients. The Department will also determine the total amount of DRG based payments made to the critical access hospital for discharges of Medicaid recipients during the respective year. Medicaid costs will be compared to payments. If payments exceed costs, the Department will not recover excess payments from the hospital. However, excess payments may be applied to any amount owed to the hospital under the critical access hospital outpatient reimbursement provisions. If costs exceed payments,

ID	TASK	QUESTIONS	RESPONSES
			the Department will reimburse the hospital the amount by which a hospital's costs exceed payments after such amount any, by which payments exceed is reduced by the amount, if costs under the Outpatient Hospital State Plan section 5100 relating to critical access hospital outpatient reimbursement. Total inpatient payments may not exceed charges as described in section 9000.
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	Information not provided.
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	Settlements are used.
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	Information not provided.
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	Information not provided.
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	Information not provided.
4.10	3/9	Does the State perform cost settlements for CAHs?	There are settlements to get to cost for DRG payments.

ID	TASK	QUESTIONS	RESPONSES
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	The number of CAHs have increased in the past 2 years.
4.12	3/9	How many CAHs are in the state currently?	There are 52 designated Critical Access Hospitals in Wisconsin.
		Trauma Services	
5.1	9	How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	Not applicable
5.2	9	Of total inpatient payments, what percentage do payments to trauma centers represent?	Not applicable
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	Not applicable
5.4	9	Does the State make special payments for Medicaid trauma care services?	Not applicable
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or	Not applicable

ID	TASK	QUESTIONS	RESPONSES
		lump sum by hospital)?	
5.6	9	What is the specific methodology used to determine payment?	Not applicable
5.7	9	How often are these payments made?	Not applicable
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	Not applicable
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	Not applicable
5.10	9	What are these specific diagnosis or procedure codes?	Not applicable
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	Not applicable
5.12	9	How have the volume of trauma care services and Medicaid trauma care payments changed over time?	Not applicable
5.13	9	Does the State have any estimates of	Not applicable

ID	TASK	QUESTIONS	RESPONSES
		Medicaid cost coverage for its trauma care services? What are they?	
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	Not applicable
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	Not applicable
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	A hospital not located in Wisconsin which has been certified by the WMAP as a border status hospital to provide hospital services to WMAP recipients. (Reference, HSS 105.48, Wis.Adm.Code) Border status hospitals are differentiated between major providers and minor providers as described in §3500.
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	• Acute services at out-of-state hospitals are based on hospital border status, as described in the State Plan Attachment 4.19a – 3520: – Non-border Status Hospitals: Out-of-state hospitals which do not have border status are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard DRG base rate which does not recognize any hospital-specific differences such as capital costs, differences in wage areas and disproportionate share adjustments. A non-border status hospital may request an adjustment for many of these factors through the administrative adjustments described in section 10400. All non-emergency services at out-of-state hospitals which do

ID	TASK	QUESTIONS	RESPONSES
			not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals. – Minor Border Status Hospitals: Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed according to section 10000 in the same manner as non-border status hospitals and may request the administrative adjustments to payment rates as described in that section. A minor border status hospital is required to provide an audited cost report to the Department (see 54022). – Major Border Status Hospitals: Major border status hospitals are reimbursed according to the DRG based payment method described under section 5000. This is the same DRG method as is used for in-state hospitals; it provides a rate that takes into account hospital-specific costs for such as capital costs. ▪ Criteria For Major Border Status: Major border status hospitals are those border status hospitals which have had 75 or more WMAP recipient discharges at least $225.000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for.(1) Medicaid HMO covered stays,(2) stays which were paid in full or part by Medicare, (3) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border

ID	TASK	QUESTIONS	RESPONSES
			status hospital. For example, the following table shows the years used for a series of annual rate updates. Annual Rate Update Effective Date Rate Years Looked – Rehabilitation Hospitals With Border Status: A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem according to section 6300 otherwise the hospital will be paid under the DRG based payment method of section 5000. A minor border status rehabilitation hospital may request payment at a per diem rate according to section 10469. Alternative Payments To Border Status Hospitals for certain Services: For any out-of-state hospital, border status or not, all inpatient stays are reimbursed under the AIDS patient care, ventilator patient care, DRG based payment method except unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to 7000.
6.3	3	If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	No.
6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	Not applicable
		Selective Contracting	

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ID	TASK	QUESTIONS	RESPONSES
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	The state does not use selective contracting.
7.2	8	What percentage of hospitals are included in the State's selective contracting program?	Not applicable
7.3	8	What services are subject to selective contracting?	Not applicable
7.4	8	What are the selective contracting payment approaches to IP services?	Not applicable
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	Not applicable
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	Not applicable
7.7	8	Is a facility-wide RCC used or departmental RCCs?	Not applicable
7.8	8	What is the source of the RCCs?	Not applicable

ID	TASK	QUESTIONS	RESPONSES
7.9	8	How often are the RCCs used for payment updated?	Not applicable
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	The state does not use a Centers of Excellence approach.
8.2	8	Describe IP Centers of Excellence programs?	Not applicable
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	Not applicable
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	Not applicable
8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	Not applicable

ID	TASK	QUESTIONS	RESPONSES
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	Not applicable
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	Yes, state IMD's are reimbursed at per diem rates.
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	Per diem.
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	Unknown.
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	WMP has enhanced the grouper's MDC 19. The WMP has expanded the nine standard DRGs of this MDC and for each of the DRGs, separate weighting factors are constructed for two age ranges: over age 17 and age 17 and younger. The result is 18 weighting factors. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals and in hospital institutions for mental disease (IMD) except Milwaukee County Mental Health Center. A separate schedule of 18 DRG weighting factors are constructed for the

ID	TASK	QUESTIONS	RESPONSES
			Milwaukee County Mental Health Center for hospital stays classified to MDC 15. Weights are calculated as described above using average cost by DRG for hospital stays in the MCMHC that are classified to MDC 15.
9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	DRGs are used.
9.6	7	Is an organization such as Regional Support Networks used for paying inpatient psych claims?	No.
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	Same as regular acute care hospitals with the exception of neonates, where DRGs are customized.
10.2		If not, does the state provide higher payment rates to children's hospitals?	Not applicable
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled	Approximately 45.4% of state Medicaid enrollees are in managed care.

ID	TASK	QUESTIONS	RESPONSES
		in managed care plans?	
11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	Plans directly negotiate with hospitals for payment rates.
		State Demographics	
12.1		Ho many Medicaid recipients do you have?	Medicaid enrollment as of June 1, 2004 was 588,876. *Data are "point-in-time" monthly enrollment counts for June 2004.*
12.2		What is your state's population?	Estimated population in 2004 was 5,509,026. *Source: U.S. Census Bureau, 2004 Population Estimates, Census 2000, 1990 Census.*

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Louisiana Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	Reimbursement for private inpatient hospital services is a prospective per diem rate for various peer groups based on 1991 cost data. Louisiana is considering implementing DRGs (targeted date on website is January 1, 2005). Exceptions to the per diem payment methodology are: • Transplant services – paid based on cost subject to a hospital-specific per diem limit that is based on each hospital's actual cost in the base year established for each type of approved transplant • Outlier policy that addresses catastrophic costs associated with services to children under six in a DSH hospital and for services to infants one year or under in all acute care hospitals (*Source:* Inpatient Hospital Services webpage -- http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=3476)

3.8	4	Describe the fixed payment per case methodology? How are payment levels determined?	• Hospitals are classified into one of five general peer groups or two specialty peer groups. Rates vary by peer group and have an operating, movable capital and fixed capital component. Payment rates are inflated annually in accordance with the State Plan contingent on the allocation of funds by the Legislature
			  ○ The payment rates for operating costs and movable equipment are according to a peer group capped amount.
			  ○ Fixed capital payment rates are based on a statewide capped amount.
			  ○ Medical education costs are reimbursed as a hospital-specific per diem amount.
			• Separate per diem for boarder babies that remain in the regular nursery of the hospital after the mother's discharges

ID	TASK	QUESTIONS	RESPONSES
			• Separate per diem rate for well babies that are discharged at the same time that the mother is discharged in private hospitals that perform more than 15000 Medicaid deliveries per year. This well baby per diem is the lesser of the hospital's actual costs or the boarder baby rate. • Separate per diems for burn unit, long term hospital care, children's hospitals, neuro and psych (*Source:* Inpatient Hospital Services webpage -- http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=3476)
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	Yes – Louisiana has a policy that addresses catastrophic costs associated with services to children under six in a DSH hospital and for services to infants one year or under in all acute care hospitals. To qualify for outlier status, a claim must have: • Covered charges that exceed 200 percent of the prospective payment • Covered charges that exceed $150,000 Louisiana pays outlier cases 100 percent of costs in excess of the prospective payment amount, and calculates cost-to-charge ratios based on the hospital's cost report period ending in SFY 2000. (*Source:* Hospital Outlier Payments webpage -- http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=3479)
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	***Pending State call – with Hurricane Katrina, I have not made any calls.***

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Inpatient Hospital Rebasing Project
Nevada Survey Matrix

ID	TASK	QUESTIONS	RESPONSES
3.7	4	Is a fixed payment per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	Yes, Nevada uses a per diem reimbursement methodology for inpatient services. In fact, from the state plan it appears that Nevada relies solely on the per diem methodology. On 1 September 2003 the state converted to a MMIS and the following services were changed from tier rates to per diem rates: (1) maternity (obstetrical hospital admissions, false labor undelivered OB and miscarriages) (2) newborns (3) medical/surgical (4) level III neonatal intensive care units (5) level I trauma centers (6) psychiatric/substance abuse treatment admissions (7) administrative day rate. (State Plan Amendment, Attachment 4.19-A)
3.8	4	Describe the fixed payment per diem methodology? How are payment levels determined?	The fixed per diem rates are determined by either a specific formula or an index based on calculated cost per day. **Maternity rate conversion** $\frac{\text{Total projected maternity payments}}{\text{CY2002 historical maternity patient days}} = \text{Maternity per diem rate}$ **Newborn rate conversion** $\frac{\text{Total projected newborn payments}}{\text{CY2002 historical newborn patient days}} = \text{Newborn per diem rate}$ **Level III Neonatal Intensive Care Unit** The current rate was developed from historical costs. The calculated cost per day of each neonatal unit was sorted from highest to lowest. The prospective per diem rate was then calculated at the 55th percentile and indexed. **Medical/Surgical rate conversion** $\frac{\text{Total projected medical/surgical payments}}{\text{CY2002 historical medical/surgical patient days}} = \text{Medical/surgical per diem rate}$

ID	TASK	QUESTIONS	RESPONSES
			Level I Trauma Centers Nevada Medicaid will pay and enhanced rate for full trauma team cases at Level I Trauma Centers. The enhanced trauma rate is 1.63 times the Medical/Surgical per diem rate. • **Psychiatric/substance abuse treatment rate** Psychiatric/substance abuse treatment costs for each hospital are divided by the number of psychiatric/substance abuse treatment days to determine a cost per day. • The Medicaid related costs of freestanding psychiatric hospitals are divided by their Medicaid costs by their total Medicaid days to determine the cost per day. • The calculated cost per day of each general acute care hospital and freestanding psychiatric hospital is arrayed from highest to lowest. • The prospective per diem rate is then calculated at the 55th percentile **Administrative day rate** The administrative rate is calculated each year and applies to patients who remain in an acute care hospital awaiting admittance to a long-term care facility. It is based on the most recent statewide weighted average payment rate for skilled and intermediate levels of care plus a 100% factor. Under certain circumstances, up to an additional 300% is added for a patient with exceptional

ID	TASK	QUESTIONS	RESPONSES
			or abnormal needs; for example, patients in need of isolation, ventilation dependency, or total parental nutrition. The administrative rate, plus the maximum 300% factor, is lower than the hospital rate as described in Part II of the State Plan. (State Plan Amendment, Attachment 4.19-A)
3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	None identified (State Plan Amendment, Attachment 4.19-A)
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	In the case of psychiatric/substance abuse treatment rate, the state has determined that a per diem rate is a more appropriate method to pay acute care hospitals providing this type of service because the costs per day for psychiatric/substance abuse treatment are predictable regardless of the length of stay.. (State Plan Amendment, Attachment 4.19-A)
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	In the case of psychiatric/substance abuse treatment rate, the state has determined that a per diem rate is a more appropriate method to pay acute care hospitals providing this type of service because the costs per day for psychiatric/substance abuse treatment are predictable regardless of the length of stay.. (State Plan Amendment, Attachment 4.19-A)
		Critical Access Hospitals	
4.1		How many CAH hospitals are	Information not provided.

ID	TASK	QUESTIONS	RESPONSES
		there statewide? What percentage of hospitals participate in the CAH program?	
4.2		Of total inpatient payments, what percentage do CAH payments represent?	Information not provided.
4.3	3/9	What method does the state use to identify CAH hospitals?	Nevada uses Medicare's CAH determination.
4.4	3/9	How does the state pay for inpatient CAH services?	Medicare's retrospective cost reimbursement system (a) Inpatient hospital services – reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR Part 413.30 and 413.40, Subpart C, and further described in CMS Publications 15-I and 15-II. (b) Interim basis—each hospital is paid for certified acute care at the lower of billed charges or the rate paid to general acute care hospitals for the same service.
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	Yes. General acute care hospitals are reimbursed per diem rates dependent on the category of service. The categories of service are (1) medical/surgical (2) newborn admissions (3) maternity (4) intensive care units (ICU) (5) neonatal intensive care unit (NICU) level III (6) trauma level I (7) administrative days.
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	Not applicable

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ID	TASK	QUESTIONS	RESPONSES
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	Information not provided.
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	Payments to CAHs are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR Part 413.30 and 413.40, Subpart C, and further described in CMS Publications 15-I and 15-II.
4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	Information not provided.
4.10	3/9	Does the State perform cost settlements for CAHs?	Annually
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	Information not provided.
4.12	3/9	How many CAHs are in the state currently?	Information not provided.